

069569 OCT 23 87


STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEMUEL WILLARD AMOSS			2a DATE OF DEATH MONTH DAY YEAR October 18, 1987		2b HOUR 9:30 AM
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 15, 1901		6 AGE (IN YEARS/LAST BIRTHDAY) 86	IF UNDER 1 YEAR MONTH DAY HOUR MIN YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford County MD	
10 CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2110 Pleasantville Road		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b KIND OF BUSINESS OR INDUSTRY Dairy
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Harford		
13c CITY OR TOWN Fallston			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Lemuel Howard Amoss			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Isadora Benson		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-38-0026		17 INFORMANT ADDRESS Fallston, Md. 21047	
17 INFORMANT ADDRESS Dr. Willard P. Amoss, 2018 Pleasantville Road					

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		6 months.
(b) Chronic Obstructive Pulmonary Disease		
DUE TO, OR AS A CONSEQUENCE OF (c) Brain Stm. cva, Aspiration Pneumonia, Anaemia.		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a Chronic Anemia - Low Pressure Hydrocephalus			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from march 19 87 to 10-18 19 87 that (I) (we) last saw the deceased alive on 9-18 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.			
22b SIGNATURE 		DEGREE MD	22c DATE SIGNED 10-19-87
22d PHYSICIAN'S NAME (TYPE OR PRINT) B. D. Parekh, M.D.		22e ADDRESS 1908 Harford Road, Fallston, Md. 21047	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Oct. 20, 1987	23c NAME OF CEMETERY OR CREMATORY Fallston U.M. Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Fallston Harford Md.
24 FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009		25a DATE REC'D. BY REGISTRAR (SEE REGISTRAR'S SIGNATURE) OCT 22 1987	

BP _____

DHMH - 16 60M 7-84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2, and file with the 72 hours after death with the State Dept. of Health and Mental Hygiene plus a small fee. (If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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COINTEGRATION

OCT 33 1981

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (PRINT) Elizabeth Badger Averill			2a DATE KNOWN OF DEATH ESTIMATED 10/23 1987			2b HOUR M		
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR 8 27 07	6 AGE (IN YEARS) (LAST BIRTHDAY) 80 YRS	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c DATE PRONOUNCED DEAD MONTH DAY YEAR 10/23 1987	7d HOUR 30 P	M
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD		
10 CITY OR TOWN OF DEATH Aberdeen		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 408 Paradise Rd.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a STATE MD			13b COUNTY Harford		
13c CITY OR TOWN Aberdeen			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS 408 Paradise Rd. 21001		
14 FATHER'S NAME FIRST MIDDLE LAST Ebert A. Badger			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lulu F. Sanderson					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b SOCIAL SECURITY NO. 213-38-7053A			17 INFORMANT ADDRESS Ebert Badger, Rt. 3, DuBois, Pa.		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART II OR PART 2)
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Luis E. Renjel TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE SIGNED 10/23/87
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D. ADDRESS 464 Alliance St. Havre De Grace, MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/27/87	23c NAME OF CEMETERY OR CREMATORY Morningside Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE DuBois Clearfield Pa.
24 FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399		25a DATE REC'D. BY REGISTRAR OCT 28 1987	25b REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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General

Adm.

James C. ...

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

29090

1. DECEASED NAME (TYPE OR PRINT) Fern Madeline Barker			2a. DATE OF DEATH MONTH 10 DAY 13 YEAR 87		2b. HOUR 8:00 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 4 DAY 5 YEAR 27		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD	
10. CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own home
13a. STATE Maryland			13b. COUNTY Cecil	13c. CITY OR TOWN Conowingo	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST Fred MIDDLE LAST Walter			15. MOTHER'S MAIDEN NAME FIRST Evelyn MIDDLE LAST Beal		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-20-7744		17. INFORMANT ADDRESS Arthur R. Barker 880 Ragan Road Conowingo, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Ischemic HT Disease DUE TO, OR AS A CONSEQUENCE OF (c) Dissecting Aortic Aneurysm APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 10/12 19 87 to 10/13 19 87 that (2) the last saw the deceased alive on 10/12 19 87 , and that in my own opinion death occurred on the date and hour and from the causes stated above; (3) and did not view the body after death.					
22b. SIGNATURE Andrew Nowakowski MD				22c. DATE SIGNED 10/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW NOWAKOWSKI MD				22e. ADDRESS 125 N. MAIN ST. BEL AIR, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/16/87	23c. NAME OF CEMETERY OR CREMATORY Conowingo Baptist		23d. LOCATION CITY OR TOWN COUNTY STATE Conowingo Cecil Maryland
24. FUNERAL DIRECTOR NAME Harkins Funeral Home, Inc. 600 Main St. Delta, PA				25a. DATE REC'D. BY REGISTRAR OCT 16 1987	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please inform the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HILDA M BLACKBURN				2a. DATE OF DEATH MONTH DAY YEAR 10 01 87				2b. HOUR 12³⁰ P.M.	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Oct. 16 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Del. Stamp & Coin Shop	
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 58 North Main St. 21904	
14. FATHER'S NAME FIRST MIDDLE LAST G. Alvin West				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie M. Santmyers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 216-20-9702		17. INFORMANT Clifton M. Blackburn, Jr.				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic abdominal carcinoma, unknown primary DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) / DUE TO, OR AS A CONSEQUENCE OF (c) / APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b. PART I OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from Aug 17 19 87 to Oct 1 19 87 that (I) (we) last saw the deceased alive on Sept. 30 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Anders Engh						DEGREE MD		22c. DATE SIGNED 10/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 5, 1987		23c. NAME OF CEMETERY OR CREMATORY HOpewell cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Port Deposit Cecil Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Lee A. Patterson & Son, Perryville, Maryland						25. DATE RECEIVED BY REGISTRAR 25a. REGISTRAR'S SIGNATURE OCT 06 1987			

MEDICAL CERTIFICATION

1011-02-1781

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067743 OCT 7 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and an autopsy will be required.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR 1. STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
		Charlotte F. Boddy				10 4 87		1005 AM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Female		Black		April 8 1947		40 yrs.		Maryland		U.S.A.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		10b. KIND OF BUSINESS OR INDUSTRY	
Maryland		U.S.A.				Harford		Dietetics Svc.		V.A.M.C., Perry	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE		13b. CITY OR TOWN	
Harford		Harford Memorial Hospital						10 Brookside Dr.		Point, Md	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		13f. CITY OR TOWN	
Maryland		Cecil		Perryville				10 Brookside Dr.		21903	
14 FATHER'S NAME (FIRST MIDDLE LAST)		15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS	
Howard Williams		Mildred Kinslow		No		212-50-5017		Jack T. Boddy		Perryville, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b and 18c. PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c) DUE TO, OR AS A CONSEQUENCE OF		18a. CARDIAC ARREST		18b. END STAGE DILATED CARDIOMYOPATHY		18c. 15 MINUTES		18d. 1 1/2 YEARS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. LOCATION (CITY OR TOWN COUNTY STATE)			
		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION (CITY OR TOWN COUNTY STATE)							
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED							
		Charles R. Eck Jr.		10/4/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Charles R. Eck Jr.		Abersdeen Md #21001		Burial		Oct. 8, 1987		Mt. Zoar Cemetery		Conowingo Cecil Maryland	
24. FUNERAL DIRECTOR (NAME ADDRESS)		25a. DATE RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Lee A. Patterson & Son, Perryville, Maryland		OCT 06 1987		Julia Davidson-Rodriguez							

BP

105-100 845530

068879 OCT 19 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) PRESTON, OWEN, BOSSOM			2a DATE OF DEATH MONTH DAY YEAR 10/11/87		2b HOUR 6:15A.M.	
3 SEX MALE	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 07 21 16		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD		
10 CITY OR TOWN OF DEATH Fallston.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Carpenter		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland		13b COUNTY Harford	13c CITY OR TOWN Forest Hill	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Raymond Bossom		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madeline Rhoten		13e STREET ADDRESS / ZIP CODE 710 Walters Mill Rd. 21050		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 213-01-1891		17 INFORMANT Pauline Bossom SAA		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure COPD. Bronchomalacia DUE TO, OR AS A CONSEQUENCE OF Gastrointestinal bleeding, CA Lung. (month) (b) (Squamous cell) DUE TO, OR AS A CONSEQUENCE OF Staph Epi - Bacteraemia. (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE		
22a I certify that (1) (this hospital) attended the deceased from 10-10-1987 to 10-11-1987 that (1) (we) last saw the deceased alive on 10-10-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) sign the body after death.						
22b SIGNATURE B.D. PAREKHI		DEGREE M.D.		22c DATE SIGNED 10-12-87		
22d PHYSICIAN'S NAME (LAST, FIRST, MIDDLE) B.D. PAREKHI M.D.		22e ADDRESS 1908 HARFORD RD, FALLSTON MD 21047				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-13-87		23c NAME OF CEMETERY OR CREMATORY Evergreen Memorial		
23d LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll Md.		24 FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home Reisterstown, Md.				
25a DATE REC'D BY REGISTRAR OCT 16 1987		25b REGISTRAR'S SIGNATURE Julia Sander-Rudner				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. FOR
STATE
REGISTRAR

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1. DECEASED NAME FIRST MIDDLE LAST Gladys S. Brown			2a. DATE OF DEATH MONTH DAY YEAR Oct. 7, 1987		2b. HOUR 4:15 pm
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec 5, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89	IF BORN IN YEAR MONTH DAY YEAR MONTH DAY YEAR
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD	
10. CITY OR TOWN OF DEATH Darlington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3657 Day Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. COUNTY Harford	13c. CITY OR TOWN Darlington	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Workman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Etta Boyce		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Marie E. Walters, 3657 Day Rd., Darlington, MD	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ARTERIO SCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>DIABETES MELLITUS + HYPERTENSION</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/7</u> 19 <u>87</u> to <u>10/7</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10/7</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>Dante Monakil M.D.</u>		DEGREE		22c. DATE SIGNED <u>10/8/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dante Monakil M.D.		22e. ADDRESS 622 S. Union St., Havre de Grace, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/11/87	23c. NAME OF CEMETERY OR CREMATORY End of the Trail		23d. LOCATION CITY OR TOWN COUNTY STATE Sam Black Greenbriar W.Va.
24. FUNERAL DIRECTOR NAME Harkins Funeral Home, Inc. 600 Main St., Delta, Pa.			25. DATE REC'D BY REGISTRAR OCT 13 1987		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

29700

1. DECEASED NAME (TYPE OR PRINT) Catherine V. BURNS			2a. DATE OF DEATH MONTH DAY YEAR Oct. 7 1987			2b. HOUR 8:00 P			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 31 03		6. AGE (IN YEARS (LAST BIRTHDAY)) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD			
10. CITY OR TOWN OF DEATH HARFORD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. STREET ADDRESS 603 Beards Hill Road 21001			
14. FATHER'S NAME FIRST MIDDLE LAST Isaac Wesley Bayless			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Ewing			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. N/A			17. INFORMANT Lois Barnhart.			ADDRESS 848 Ontario St. Harve de Grace, Md. 21078			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Renal Failure 20 to Septic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Ate 20 to Cerebral Hypoxia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>about 6 weeks.</u>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Anesthetized Pneumonia / Decubitus Ulcer</u>	
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>Not applicable</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, CHURCH, PARK, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8-20</u> 19 <u>87</u> to <u>10-7</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-7</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Mammie M. Lazzatin, M.D.				DEGREE		22c. DATE SIGNED 10/8/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAZZATIN, MAMMIE	
22e. ADDRESS PO Box 579 8 Law St. Aberdeen, Md. 21001				22f. ADDRESS		22g. ADDRESS		22h. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/10/87		23c. NAME OF CEMETERY OR CREMATORY Wesleyan Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford Md.		23e. DATE REC'D. BY REGISTRAR OCT 13 1987	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399		24. FUNERAL DIRECTOR ADDRESS		24. FUNERAL DIRECTOR ADDRESS		24. FUNERAL DIRECTOR ADDRESS		24. FUNERAL DIRECTOR ADDRESS	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be notified within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) Ernest William Chambers, Sr.				2a DATE OF DEATH MONTH 10 DAY 25 YEAR 87				2b HOUR 755 A	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH March DAY 10 YEAR 1908		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7 UNDER 24 HRS MONTH DAY HOUR MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10 CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a USUAL OCCUPATION (TYPE OF WORK) Inspector		12b KIND OF BUSINESS OR INDUSTRY US-govt. Ret.	
13a STATE Maryland				13b COUNTY Harford		13c CITY OR TOWN Edgewood		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST Ernest MIDDLE Lee LAST Chambers				15 MOTHER'S MAIDEN NAME FIRST Virginia MIDDLE Evangeline LAST Chewning					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT Mrs. Helen G. Chambers, 2217 Perry Ave, Edgewood Md. 21040					

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio pulm arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CA of lung e metastases, CHT DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (2) (we) last saw the deceased alive on _____, 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (3) (we) (did) (did not) view the body after death							
22b SIGNATURE Antonino A. Calan				DEGREE MD		22c DATE SIGNED 10-26-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ANTONINO A. CALAN, M.D.				22e ADDRESS 611 S. Union Ave., Harre de Grace			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 28, 1987		23c NAME OF CEMETERY OR CREMATORY Cokesbury U.M. Cemetery		23d LOCATION CITY OR TOWN Abingdon COUNTY Harford STATE Md.	
24 FUNERAL DIRECTOR NAME Howard K. McComas III				ADDRESS Abingdon, Md. 21009			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4 should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-82-100-5-100-1

10-82-100-5-100-1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

2a DECEASED NAME (PRINT)			3 SEX			4 RACE			5 DATE OF BIRTH			6a DATE OF DEATH			6b HOUR		
FIRST MIDDLE LAST Samuel Caravello			Male			Caucasian			MONTH DAY YEAR Dec. 1, 1901			MONTH DAY YEAR October 26, 1987			9 P.M.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH								
Palermo, Sicily			U.S.A.						Harford								
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY								
Belair			513 Normandy Lane, 21014			retired pipefitter			Beth.St.								
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b STATE			13c COUNTY			13d CITY OR TOWN			13e INSIDE CITY LIMITS?			13f STREET ADDRESS / ZIP CODE		
			MD.						Balto.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			145 S. East Avenue, 21224		
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
Thomas Caravello			Rose														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO			17 INFORMANT											
no			213-09-0931			Teresa Caravello-Abramowski, 21014											
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u><i>Ischemic Coronary</i></u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u><i>1 Month</i></u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that (1) (this hospital) attended the deceased from <u><i>12/1</i></u> , 19 <u><i>87</i></u> to <u><i>10/26</i></u> , 19 <u><i>87</i></u> that (2) (yes) last saw the deceased alive on <u><i>10/8</i></u> , 19 <u><i>87</i></u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (3) (we) (did) not view the body after death.																	
22b SIGNATURE			DEGREE						22c DATE SIGNED								
<i>[Signature]</i>									10/7/87								
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS														
M. L. HALL			4741 Eastern Ave BALT MD 21224														
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION CITY OR TOWN COUNTY STATE								
Burial			10/30/87			Sacred Heart of Jesus			Baltimore, Maryland								
24 FUNERAL DIRECTOR NAME ADDRESS			25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE											
Joseph N. Zannino, 263 S. Conkling St. 21224			OCT 29 1987			<i>[Signature]</i>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph Stanley Chilcoat			2a. DATE OF DEATH MONTH 10 DAY 31 YEAR 87		2b. HOUR 830 A M
3. SEX MALE	4. RACE White	5. DATE OF BIRTH Feb 13, 1916 MONTH 2 DAY 13 YEAR 16		6. AGE (IN YEARS (LAST BIRTHDAY)) 71 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD	
10. CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LINE FOREMAN	12b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
13a. STATE Maryland	13b. COUNTY Harford Co.	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 207-C 207 Crocker Drive - Apt. C Bel Air, Maryland 21014	
14. FATHER'S NAME FIRST John MIDDLE Stanley LAST Chilcoat		15. MOTHER'S MAIDEN NAME FIRST Marie MIDDLE Ellen LAST Schmidt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-07-8761		17. INFORMANT (NAME) Mrs. O. Faye Chilcoat ADDRESS 207-C 207 Crocker Drive - Apt. C Bel Air, Maryland 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Vent Rhythmic Cardia. "shock" Hypotension DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Metabolic acidosis. DUE TO, OR AS A CONSEQUENCE OF (c) Spontaneous Cerebral Lung with pneumonia setting 6 months. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-31 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.					
22b. SIGNATURE B. PAREKH MD.		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 1908 HARFORD RD, FALLSTON MD 21047			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 3, 1987	23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (CITY OR TOWN) COUNTY STATE Bel Air, Harford Co., Maryland 21014	
24. FUNERAL DIRECTOR Joseph William Foster Frederick J. Foster		25a. DATE REC'D. BY REGISTRAR NOV 03 1987		25b. REGISTRAR'S SIGNATURE Julia Decker-Randall	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

FOR
1- STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

Anna Caroline Cochran

2a DATE OF DEATH MONTH DAY YEAR 2b HOUR AM
Oct. 4, 1987 2:20 AM

3 SEX

Female

4 RACE

White

5 DATE OF BIRTH

JAN 5, 1999

6 AGE (IN YEARS LAST BIRTHDAY)

88

7a BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)

North Carolina

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Harford

MD

10 CITY OR TOWN OF DEATH

Fallston

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Fallston Gen. Hosp.

12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b KIND OF BUSINESS OR
INDUSTRY

--

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

MD

13b COUNTY

Harf.

13c CITY OR TOWN

Soppa

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

3407 Clayton Rd 21085

14 FATHER'S NAME

Norman

MIDDLE

C.

LAST

Reed

15 MOTHER'S MAIDEN NAME

Leota

MIDDLE

--

LAST

Sturgil

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

no

16b SOCIAL SECURITY NO

--

17 INFORMANT

212-74-9138

ADDRESS

Helen G. Dorman, 8 Valiant Drive, Abingdon, Md. 21009

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RENAL FAILURE

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) Hepato-renal syndrome with Ascites.

DUE TO, OR AS A CONSEQUENCE OF

(c) Hepatic Tumor.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

C.H. Failure - Ischemic Heart Disease - R (small) pleural effusion

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 9/19/87 to 10/4/87 that (we) last

saw the deceased alive on 10/4/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b SIGNATURE

D. L. Pirovolidis MD. PA

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c DATE SIGNED

10/4/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

D. L. Pirovolidis MD. PA

22e ADDRESS

2112 Bel Air Rd FALLSTON, Md. 21047

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b DATE

Oct. 6, 1987

23c NAME OF CEMETERY OR CREMATORY

Bel Air Memorial Gardens

23d LOCATION

CITY OR TOWN

Bel Air

COUNTY

Harford

STATE

Md.

24 FUNERAL DIRECTOR

NAME

Howard K. McComas III, Abingdon, Md. 21009

ADDRESS

25a DATE REC'D BY REGISTRAR

OCT 06 1987

25b REGISTRAR'S SIGNATURE

Julia Davidson-Rodden

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy pages 1 and 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the death certificate must be notified or noted.

067738 OCT-7-87

061-39 OCT-5 67

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST Elbert

MIDDLE Evans

LAST Collins Jr

2a DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 10 28 87 2b HOUR 1:40 AM

3 SEX Male

RACE White

5 DATE OF BIRTH MONTH DAY YEAR 12 30 32

6 AGE (IN YEARS) 54

IF UNDER 1 YR MONTHS DAYS

IF UNDER 24 HRS HOURS MIN

2c DATE PRONOUNCED DEAD 10 28 87 2d HOUR 1:40 AM

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA

7b CITIZEN OF WHAT COUNTRY? USA

8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH Fallston Harford MD.

10 CITY OR TOWN OF DEATH Fallston

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General

12a USUAL OCCUPATION (TYPE OF WORK) Supply Clerk

12b KIND OF BUSINESS OR INDUSTRY US-govt.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE Md

13b COUNTY HARFORD

13c CITY OR TOWN Bel Air

13d INSIDE CITY LIMITS? YES ☐ NO ☒

13e STREET ADDRESS 1495 Oak Dr Bel Air 21014

14 FATHER'S NAME FIRST Elbert

MIDDLE Evans

LAST Collins, Sr.

15 MOTHER'S MAIDEN NAME FIRST Hattie

MIDDLE Grace

LAST Colvin

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes

16b SOCIAL SECURITY NO. 465-464476

17 INFORMANT William H. Clark, 1 Wye Oak Drive Bel Air, Md. 21014

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASCVD
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION
19b CONDITION FOR WHICH OPERATION WAS PERFORMED?
20 AUTOPSY? YES ☐ NO ☐
21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) M.D. Deput
EXAMINER'S NAME LUI E Remyel ADDRESS 464 Alliance St Harford Md.
DATE SIGNED 10-27-87

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
23b DATE Oct. 30, 1987
23c NAME OF CEMETERY OR CREMATORY St. George's Episcopal Cem. Perryman
23d LOCATION CITY OR TOWN COUNTY STATE Harford Md.
24 FUNERAL DIRECTOR Howard K. McComas III, Abingdon, Md. 21009
DATE REC'D. BY REGISTRAR OCT 30 1987 REGISTRAR'S SIGNATURE Julia Gordon-Baker

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP
DHMH-17
(VR A15 ME (5))
15M7/77

070372

11 NOV 2 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

29700
20 DATE OF DEATH MONTH DAY YEAR 27 1987
2b HOUR 1:30 PM1 DECEASED NAME
(TYPE OR PRINT)

Charles Harry Curtin

3 SEX

Male

4 RACE

White

5. DATE OF BIRTH

5 - 19 - 1916

6 AGE (IN YEARS LAST BIRTHDAY)

71

IF UNDER 1 YEAR IF UNDER 15 HRS

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

NEW YORK

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

HARFORD

MD

10 CITY OR TOWN OF DEATH

ABERDEEN

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

3644 CHURCHVILLE ROAD

12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

RET. US ARMY

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

MARYLAND

13b COUNTY

HARFORD

13c CITY OR TOWN

ABERDEEN

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS

3644 CHURCHVILLE RD/21028

14 FATHER'S NAME

HARRY

MIDDLE

CURTIN

15 MOTHER'S MAIDEN NAME

RENE

MIDDLE

DABNEY

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

YES

16b SOCIAL SECURITY NO.
(IF YES, GIVE NO. OR DATES)

WW II

16b SOCIAL SECURITY NO.

098-03-662

17. INFORMANT

PATRICIA A. BOHNENBERG; 8103 ANACAPLE DR.

ADDRESS

BALTO. MD 2

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

CONGESTIVE HEART FAILURE

1-2 YEARS

DUE TO, OR AS A CONSEQUENCE OF

(c)

CHRONIC LUNG DISEASE

YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

C. Eck

DEGREE

MD

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c DATE SIGNED

10/22/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

CHARLES R. ECK JR.

22e ADDRESS

223 W. BELAIR AVE, ABERDEEN, MD

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

REMOVAL/CREMATION

23b DATE

10-30-87

23c NAME OF CEMETERY OR CREMATORY

R.A. FERRIS & Co

23d LOCATION

WEST CHESTER, CHESTER, PA

24 FUNERAL DIRECTOR

NAME

TARRING FUNERAL HOME, PA. ABERDEEN MD 21001-334

25a DATE REC'D. BY REGISTRAR

OCT 30 1987

25b REGISTRAR'S SIGNATURE

Julia Jackson-Budnick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

William P Damico

2a DATE OF DEATH

MONTH

DAY

YEAR

10-29-87

2b HOUR

9:20 AM

3 SEX

MALE

4 RACE

WHITE

5 DATE OF BIRTH

MONTH

DAY

YEAR

4 12 05

6 AGE (IN YEARS LAST BIRTHDAY)

82 YRS

IF UNDER 1 YEAR

MONTHS DAYS HOURS MIN

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

NEW YORK

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

HARFORD COUNTY

MD

10 CITY OR TOWN OF DEATH

HAVRE de GRACE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

HARFORD MEMORIAL HOSPITAL

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

(RET) TRANSP. CLERK

12b KIND OF BUSINESS OR INDUSTRY

IBM CORP

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

MD

13b COUNTY

HARFORD

13c CITY OR TOWN

HAVRE de GRACE

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

1722 OETHS FORO ROAD

21078

14 FATHER'S NAME

FIRST MIDDLE LAST
ANTONIO

D'AMICO

15 MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
MARIANINA

AIELLO

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)

021092248

17 INFORMANT

MRS. ROSINA R. O'AMICO

ADDRESS

SAME AS #13e

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) ARTERIOSCLEROSIS

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

ANEMIA

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

19c AUTOPSY?

YES ☐ NO ☒20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 2B, PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)

21f LOCATION (CITY OR TOWN)

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 10/29/87 to 10/29/87 that (I) (we) last saw the deceased alive on 10/29/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death

22b NATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c DATE SIGNED

10/29/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

DANTE MONAKIL, MD

22e ADDRESS

Harve de Grace, Md 21078

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

CREMATION

23b DATE

30 OCTOBER 87

23c NAME OF CEMETERY OR CREMATORY

R. A. FERRIS + CO.

23d LOCATION (CITY OR TOWN)

WEST CHESTER,

COUNTY

STATE

PA.

24 FUNERAL DIRECTOR

NAME

ADDRESS

MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD. 21078

25a DATE REC'D. BY REGISTRAR

NOV 2 1987

25b REGISTRAR'S SIGNATURE

Julia Swider-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and received by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them in your files with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

69342 OCT 22 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

29708

FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RALPH CARTER Dettor			2a DATE OF DEATH MONTH DAY YEAR 10-18-87		2b HOUR 10³⁴ 10P^M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 11 21 04		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH FALLSTON		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN. HOSPITAL		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY Clendenian Bros.				
13a STATE Maryland		13b COUNTY Harford		13c CITY OR TOWN Fallston		
14 FATHER'S NAME FIRST MIDDLE LAST Robert Dettor		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Md.21047				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 215-03-4594		17 INFORMANT ADDRESS Mrs. Suzanne Chester 2212 Larchmont Dr. Fallston, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) fracture right hip = dislocation & right tibia PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) aortic aneurysm surgery						
19a DATE OF OPERATION Oct 13 '87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED fracture dislocation right hip		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 OR PART 2) auto accident		
21d INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) street		21f LOCATION CITY OR TOWN COUNTY STATE Fallston Harford MD		
22a I certify that (I) (this hospital) attended the deceased from October 13 (13) 19 87 to October 18 19 87 that I (we) last saw the deceased alive on October 18 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE John N. Lee				22c DATE SIGNED Oct 18 '87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) John N Lee M.D				22e ADDRESS 601 S Union Ave HOG MD		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 10-20-87		23c NAME OF CEMETERY OR CREMATORY Westview Memorial Pk.		
23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		23e NAME OF CEMETERY OR CREMATORY Westview Memorial Pk.		23f LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24 FUNERAL DIRECTOR NAME E.F. LASSAHN Funeral Home		ADDRESS 11750 Belair Rd Kingsville, Md 21087		25a DATE REC'D BY REGISTRAR OCT 21 1987		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, mostly illegible handwritten text on lined paper. The text appears to be a letter or a report, with several lines of cursive script. Some words like "Dear" and "Yours" are faintly visible.]

069352 OCT 22 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

29709
20 DATE OF DEATH MONTH DAY YEAR 2b HOUR
October 19, 1987 10:35 AM1 DECEASED NAME FIRST MIDDLE LAST
FRANCES Lorinne Denney3 SEX
Female4 RACE
White5. DATE OF BIRTH MONTH DAY YEAR
June 9 19146 AGE (IN YEARS LAST BIRTHDAY) 73 YRS
8 UNDER 1 YEAR 9 UNDER 24 HRS
MONTHS DAYS HOURS MIN.7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna.7b CITIZEN OF WHAT COUNTRY?
USA8 MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐9 BALTIMORE CITY OR COUNTY OF DEATH
Harford MD10 CITY OR TOWN OF DEATH
Havre de Grace11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Harford Memorial Hospital12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker

12b KIND OF BUSINESS OR INDUSTRY

13a STATE
Maryland13b COUNTY
Harford13c CITY OR TOWN
Havre de Grace13d INSIDE CITY LIMITS? YES ☐ NO ☒
13e STREET ADDRESS
1006 Morrison Blvd. 2107814 FATHER'S NAME FIRST MIDDLE LAST
Mahlon Kendall15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Helen E. Garnes-Fassnacht16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
16b SOCIAL SECURITY NO.
298-14-814317 INFORMANT ADDRESS
Ben G. Denney, Jr. same as 1318 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Recurrent C.V.A.
DUE TO, OR AS A CONSEQUENCE OF (b) A.S. C.V.D. E
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery DiseaseAPPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days
2-3 yearsPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
Collagenous Colitis, Aspiration Pneumonitis19a DATE OF OPERATION
19b CONDITION FOR WHICH OPERATION WAS PERFORMED
19c AUTOPSY? YES ☐ NO ☒
19d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21a INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ WORK ☐

21b PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)

21c LOCATION STREET CITY OR TOWN COUNTY STATE

22 I certify that (I) (this hospital) attended the deceased from 10/19/87 to 10/19/87 that (I) (we) last saw the deceased alive on 10/19/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE
(Signature)DEGREE
MD22c DATE SIGNED
10/19/8722d PHYSICIAN'S NAME (TYPE OR PRINT)
E.C. Loo, M.D.22e ADDRESS
Havre de Grace, Md.23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial23b DATE
Oct. 21, 198723c NAME OF CEMETERY OR CREMATORY
Mt. Erin Cemetery23d LOCATION CITY OR TOWN COUNTY STATE
Havre de Grace Harford Md24 FUNERAL DIRECTOR NAME
Mitchell Funeral HomeADDRESS
Havre de Grace MD25a DATE REC'D BY REGISTRAR
OCT 21 198725b REGISTRAR'S SIGNATURE
(Signature)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP
DHMH - 16 50M 1/81
(VRA 15, 4)TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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070728 NOV 14 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ellen M Dietz			2a DATE OF DEATH MONTH DAY YEAR 10/30/87		2b HOUR 1:17 AM	
3 SEX FEMALE		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 10 22 14		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		
10 CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.-Farmer		
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN FALLSTON		
14 FATHER'S NAME FIRST MIDDLE LAST Frank Misner		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Schafferman		17 INFORMANT ADDRESS Joan M. Parsons 1216 Narcissus Ave. 21239		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO 213-20-1475		17b ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION (CITY OR TOWN) COUNTY STATE 10/29/87 10/29/87 1987		
22a I certify that (I) (this hospital) attended the deceased from 10/30/87 to 10/30/87 that (I) (we) last saw the deceased alive on 10/30/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE Dante Monakik MD		DEGREE MD		22c DATE SIGNED 10/30/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIK		22e ADDRESS Harold Cross, Md 21078				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 11-2-87		23c NAME OF CEMETERY OR CREMATORY St. Michael Luth.Ch.		
23d LOCATION (CITY OR TOWN) COUNTY STATE Baltimore, Maryland		24 FUNERAL DIRECTOR NAME ADDRESS Lassahn Funeral Home 7401 Balas				
25a DATE REC'D BY REGISTRAR NOV 03 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall				

BP

53 14 101 03 05 0

718

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

5
070113 OCT 29 1987

1. DECEASED NAME (TYPE OR PRINT) MAY Mary ESTHER ELLIOTT		2a. DATE OF DEATH MONTH DAY YEAR October 23, 1987		2b. HOUR P. M. 10:30 P. M.	
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 7, 1989		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co., MD	
10. CITY OR TOWN OF DEATH Bel Air	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker
13a. STATE Maryland		13b. COUNTY Harford Co.	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry CREVENSTEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rida JAMES		13e. STREET ADDRESS / ZIP CODE 126 Hickory Court 21014	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-74-3979 215-03-4446-D		17. INFORMANT (Daughter) 836-0276 ADDRESS 1102-I Iron Bucket Court Mrs. Esther E. Wheeler Bel Air, Maryland 21014	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery Disease (Probable) 10-20 years DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Severe Osteoporosis, Depression					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from July 19, 87 to 10/23, 1987 that (2) we last saw the deceased alive on Approx. Oct. 19, 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.					
22b. SIGNATURE J.K. Lynch MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.K. LYNCH MD		22e. ADDRESS 401 FRANKLIN ST. Bel Air, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE Oct. 26, 1987		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum	
23d. LOCATION (CITY OR TOWN COUNTY STATE) Baltimore, Maryland		23e. DATE REC'D BY REGISTRAR OCT 26 1987			
24. FUNERAL DIRECTOR Joseph William Foster 50 W. Broadway a Williams St. Joplinville Inter Bel Air, Maryland 21014		25a. DATE REC'D BY REGISTRAR OCT 26 1987			

070113 OCT 28 64

RECEIVED
OFFICE OF THE
ATTORNEY GENERAL

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or letter. It contains several lines of text, some of which may be headings or body text, but the specific words are not discernible.]

068060 OCT 1987

Item 18, 19, 21a, c, d, e, f, 22a, 22b, 22c, 22d, 22e, 22f, 22g, 22h, 22i, 22j, 22k, 22l, 22m, 22n, 22o, 22p, 22q, 22r, 22s, 22t, 22u, 22v, 22w, 22x, 22y, 22z, 23a, 23b, 23c, 23d, 23e, 23f, 23g, 23h, 23i, 23j, 23k, 23l, 23m, 23n, 23o, 23p, 23q, 23r, 23s, 23t, 23u, 23v, 23w, 23x, 23y, 23z, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

FOR dw per med exam

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			2a DATE KNOWN OF DEATH ESTI MATED			2b HOUR		
Raymond A. Epps			10/ 2/19 87			M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS	7c DATE PRONOUNCED DEAD	7d HOUR	
M	N. 2	9-7-48	39 YRS.			10/ 2/19 87	8:25 P.M.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			7c BALTIMORE CITY OR COUNTY OF DEATH		
M.D.			U.S.A.			Harford County, MD		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Havre deGrace			Harford Memorial Hospital			Labor		
13a STATE			13b COUNTY			13c CITY OR TOWN		
M.D.			Harford			Harford Co.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16 STREET ADDRESS		
James Jackson			Helen Epps			605 Dembytown Rd #21025		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS		
yes			215-46-9003			Helen Jackson 605 Dembytown Rd #21025		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1 DEATH WAS CAUSED BY								
IMMEDIATE CAUSE (a):								
DUE TO, OR AS A CONSEQUENCE OF								
Arteriosclerotic Cardiovascular Disease								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last								
(b):								
DUE TO, OR AS A CONSEQUENCE OF								
(c):								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
Chronic Alcoholism and Arteriosclerotic Cardiovascular Disease								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
			P.M. 19			Subject used drugs		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)			21f LOCATION CITY OR TOWN COUNTY STATE		
			Home			605 Dembytown Road, Joppa, Harford County, MD		
22a I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Charles P. Kokes			M.D. Assistant			10/4/87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Charles P. Kokes, M.D.			111 Penn St., Balto., Md. 21201					
23a BURIAL CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY		
Burial			10/8/87			Garrison Forest Cem.		
23d LOCATION CITY OR TOWN COUNTY STATE			23e DATE REC'D BY REGISTRAR			23f REGISTRAR'S SIGNATURE		
Owens M. Hs MD.			OCT - 6 1987			Julia Harrison		
24 FUNERAL DIRECTOR NAME			ADDRESS			25a DATE REC'D BY REGISTRAR		
Betts Funeral Home			1129 N. Caroline St.			OCT - 6 1987		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE COMPLETED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-EM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

107-84
25MDHMH - 17
(VR A15 ME (1))

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20% COTTON FIBER

CHIEF WALK

CHIEF WALK



070625 NOV - 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

29713

1. DECEASED NAME (TYPE OR PRINT) Iris Agnes Ferguson			2a. DATE OF DEATH MONTH DAY YEAR 10 29 87			2b. HOUR 1708 PM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Feb. 26, 1911		
6. AGE (IN YEARS (LAST BIRTHDAY)) 76 YRS.			7. BIRTHPLACE (STATE OR REGION) West Virginia			8. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD		
9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD			10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen Hosp		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY --			13. STREET ADDRESS / ZIP CODE 1951 Edgewater Drive 21040		
14. FATHER'S NAME FIRST MIDDLE LAST John -- Wagner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Rae Board			16. SOCIAL SECURITY NO 214-36-8607		
17. INFORMANT ADDRESS Agnes H. Shaffer, 526 Rogers St. Aberdeen, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) medullary collapse DUE TO, OR AS A CONSEQUENCE OF (b) massive subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) --			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21c. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21d. LOCATION STREET CITY OR TOWN COUNTY STATE			21e. INJURY OCCURRED WHILE AT HOME <input type="checkbox"/> NOT WHILE AT HOME <input type="checkbox"/>		
22a. I certify that (1) this hospital attended the deceased from 10/27 19 87 to 10/29 19 87 that (1) we last saw the deceased alive on 10/29/87 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not see the body after death)								
22b. SIGNATURE J. Douglas Abbott M.D.			22c. ADDRESS Suite 106 1716 Harford Rd Fallston Md.			22d. DATE SIGNED 10/29/87		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 2, 1987			23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens, Middle River Balto.		
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009			25a. RECEIVED BY REGISTRAR NOV 2 1987		
25b. REGISTRAR'S SIGNATURE James Davidson-Randolph								

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial permit. These please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

070622 101-331

JP

RECEIVED
12/16/71
NAVY ROTUND KOD

NAVY ROTUND KOD

NOV 5 1971

069354 OCT 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NEAL DOUGLAS FERGUSON, SR.			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 18, 1987		2b. HOUR 1:42 PM		
3. SEX MALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 9, 1943		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 44	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b. KIND OF BUSINESS OR INDUSTRY US-govt. Ret.	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Abingdon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 1103 Abingdon Road 21009		14. FATHER'S NAME FIRST MIDDLE LAST Neal Harry Ferguson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Florabelle Thomas		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 215-42-5860		17. INFORMANT ADDRESS Abingdon, Md. 21009		17. INFORMANT NAME Josephine Ferguson Dorman, 1103 Abingdon Rd.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio-Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Severe Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) 	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (1) (this hospital) attended the deceased from 19 to 19 , that (1) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.							
23. SIGNATURE Joseph Jack, Jr., M.D.				DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-19-87	
23d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 672 Townecenter Drive, Joppatowne, Md. 21085			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 22, 1987		23c. NAME OF CEMETERY OR CREMATORY John Wesley U.M. Cemetery, Abingdon Harford Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009				25. DATE REC'D BY REGISTRAR (25b. REGISTRAR'S SIGNATURE) OCT 21 1987			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the legal director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (page 4) and 2 should be filed with the legal director. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical director must be notified and a coroner's inquest may be required.

BP

PC

ALBANY, NEW YORK, 1873

1873 OCT 25

My dear Sir,

I have the pleasure to

acknowledge the receipt of

your letter of the 10th inst.

in relation to the

subject of the

above mentioned

matter.

I am, Sir, very respectfully,

Yours truly,

3 1
0692] 3 OCT 21 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

29715

1. DECEASED-NAME (Type or print) GLADYS IRENE FERRALL			2a. DATE OF DEATH OCT Month 17 Day 87 Year		2b. HOUR 10:25 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH 12/11/04		6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? USA	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Hartford Co.		
10. CITY OR TOWN OF DEATH Forest Hill	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY Hartford	13c. CITY OR TOWN Forest Hill	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 213A Marshall Drive	
14. FATHER'S NAME First Middle Lost William Hohler		15. MOTHER'S MAIDEN NAME First Middle Lost			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. 283-48-1747		17. INFORMANT Address Jack Ferrall same (son)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ascvd DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs many years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus (10 yrs)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> If either, notify medical examiner			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1980 , to 10/17 , 19 87 , that (I) (we) last saw the deceased alive on 8/17 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Phyllis K. Pullen MD DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/17/87	
22d. PHYSICIAN'S NAME (Type) Phyllis K. Pullen MD		22e. ADDRESS 2807 Jerusalem Rd., Kingsville, Md 2108			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-17-87	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR State Anatomy Board		ADDRESS Balto., Md.		25a. REC'D BY REGISTRAR 19 1987 DATE	
				25b. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 24 hours after death.

065113 06101



070031 OCT 23 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29716

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
DOROTHY		MAE				FREY		DATE ESTI- MATED		19						M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	White	Oct. 16, 1927		60 YRS.		MONTHS		DAYS		HOURS		MIN		10:05		A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		USA		WIDOWED		DIVORCED		Harford County								MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY											
Joppa		103 Orsburn Drive		Beautician		Beauty Shop											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Harford		Joppa		YES		103 Orsburn Drive								21085	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
George		Pflugrad		Carolyn		Smith											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no		220-20-6023		Gale Frey,		14 Oregon Ave, New Castle, Del.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																	
PART I DEATH WAS CAUSED BY																	
IMMEDIATE CAUSE (a)		Coronary heart disease															
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause last																	
(b)		A S C V D															
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES		NO											
21a. EXTERNAL CAUSE WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED													
OR CONTRIBUTING CAUSE OF DEATH		P.M.		19													
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION													
NOT WHILE AT WORK		(AT HOME STREET, FACTORY, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an		Autopsy		Inspection		Inquiry		and in my opinion									
death resulted from		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Luis E. Renjel		M.D. Deputy		MEDICAL EXAMINER		10-21-87											
EXAMINER'S NAME		ADDRESS															
(TYPE OR PRINT)		Luis E. Renjel, M.D.		464 Alliance St., Havre deGrace, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
Cremation		Oct. 26, 1987		R.A. Ferris Crematory		W. Chester		Chester		Pa.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Howard K. McComas III		Abingdon, Md.		21009		001 27 1987											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3 AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. MAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

NOV 18 1897



Wm. L. ...

REG NO

DECEASED NAME (TYPE OR PRINT)		FIRST Rose		MIDDLE A.		LAST Galinis		2a. DATE KNOWN OF DEATH EST. MATED <input checked="" type="checkbox"/> 10/31/87 10:00 AM	
5a. SEX Female	4. RACE Cauc.	1. DATE OF BIRTH MONTH DAY YEAR 12 14 09		6. AGE (IN YEARS) (LAST BIRTHDAY) YES 77		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 10/31/87 10:00 AM	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		1. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD			
10. CITY OR TOWN OF DEATH Forest Hill		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) 1413 Kahoe Rd.				12a. USUAL OCCUPATION (TYPE OR HOW FOR ADULT OR WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Clothing Co.	
13a. STATE MD		13b. COUNTY Harford		13c. CITY OR TOWN Forest Hill		13d. HOME CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1413 Kahoe Rd. 21050	
14. FATHER'S NAME FIRST MIDDLE LAST unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antoinette Andricks				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
17. SOCIAL SECURITY NO. 212 10 2507				18. INFORMANT Mrs. June Potter, Dghtr, same as above				19. ADDRESS above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. PLACE OF INJURY STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>L. Renjel</u>		TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER DATE SIGNED 11/2/87			
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.		ADDRESS 464 Alliance St. Havre De Grace, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/4/87		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto, Md.			
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, Balto, Md. 21236		25a. DATE REC'D. BY REGISTRAR NOV 3 1987		25b. REGISTRAR'S SIGNATURE <u>L. Renjel</u>					

MEDICAL CERTIFICATION

DHMH 17
(VR A15 ME (5))

Commander J. H. ...
A 1200

[Handwritten signature]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

29718

FOR
1- STATE
REGISTRAR

DECEASED NAME
(OR PRINT)

FIRST

MIDDLE

LAST

Helen

Marie

Gay

2a DATE KNOWN OF DEATH
DATE OF DEATH MATED ☒ 10/29 1987 11aM

3 SEX

F

4 RACE

W

5 DATE OF BIRTH

MONTH DAY YEAR
6 23 09

6 AGE (IN YEARS)

(LAST BIRTHDAY)
78 YRS.

IF UNDER 1 YR

MONTHS DAYS HOURS MIN

IF UNDER 24 HRS

7c DATE PRONOUNCED DEAD

MONTH DAY YEAR

10/29 1987

7d HOUR

11aM

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MD

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Harford

MD

10 CITY OR TOWN OF DEATH

Fallston

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN HOSPITAL, GIVE STREET ADDRESS)
Fallston General Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b KIND OF BUSINESS OR INDUSTRY

Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

MD

13b COUNTY

Harford

13c CITY OR TOWN

Street

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS

2025 Jerry's Rd.

21154

14 FATHER'S NAME

William

MIDDLE

LAST

Schrieber

15 MOTHER'S MAIDEN NAME

Margaret

FIRST

MIDDLE

LAST

Wendler

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

16b SOCIAL SECURITY NO

216 05 6648

17 INFORMANT

ADDRESS

Richard B. Gay 2025 Jerry's Rd.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

ASCVD - Coronal heart DB

ASCVD

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☐ NO ☒

21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Luis E. Renjel

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE SIGNED

10/30/87

EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.

ADDRESS 464 Alliance St. Havre De Grace, MD X

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

11/1/1987

23c NAME OF CEMETERY OR CREMATORY

Holy Cross Cem.

23d LOCATION

Street, Harford, Md.

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

M. Gladden Kurtz

ADDRESS

Jarrettsville, Md.

25a DATE REC'D BY REGISTRAR

NOV 04 1987

25b REGISTRAR'S SIGNATURE

Gina Davidson

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

071234 11-001

8

Home
Boulevard
Hospice
11/18/87



11/18/87
Hospice
Boulevard
Home
11/18/87
Hospice
Boulevard
Home

067736 OCT 7-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

297

1. DECEASED NAME (TYPE OR PRINT) John W. Gillespie, Jr.		2a. DATE OF DEATH MONTH DAY YEAR 10-2-87		2b. HOUR 3:01 PM
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 4 25 23		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD
10. CITY OR TOWN OF DEATH Hartford de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator	12b. KIND OF BUSINESS OR INDUSTRY Dundalk College
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John William Gillespie, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathryn Sweeney		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO Korea & V.N 074-12-2606		
17. INFORMANT Helen Gillespie		ADDRESS same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) COPD				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2, OR PART 3)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on above; (II) (we) (did) (did not) view the body after death				
22b. SIGNATURE Brian T. Jones MD		22c. DATE SIGNED 10/2/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT)
22e. ADDRESS		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/8/87	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.	23d. LOCATION (CITY OR TOWN) COUNTY STATE Arlington Arlington Va.
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399		25a. DATE REC'D. BY REGISTRAR OCT 06 1987		
25b. REGISTRAR'S SIGNATURE John Davidson-Rodell				

087706 OCT-701

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100% COTTON YARN

100% COTTON

100% COTTON

100% COTTON

100% COTTON

100% COTTON

070211 OCT 29 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

29720

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTHONY A. GIORDANO			2a. DATE OF DEATH MONTH DAY YEAR 10 21 87		2b. HOUR 7:15 P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 31 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD	
10. CITY OR TOWN OF DEATH Bel Air	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Chemical
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Fallston	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1701 Arabian Way 21047
14. FATHER'S NAME FIRST MIDDLE LAST Pasquale Giordano		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna DelliBovi		16. SOCIAL SECURITY NO. 153-03-6025	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 153-03-6025		17. INFORMANT Charmaine Brankowitz	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Parkinson's disease DUE TO, OR AS A CONSEQUENCE OF (c) dementia					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) History of cerebral vascular accident					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2 OR PART 3)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 9/8 19 87 to 10/21 19 87 that (1) (we) last saw the deceased alive on 10/15 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death					
22b. SIGNATURE DAVID McElure MD				22c. DATE SIGNED 10/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID McElure MD				22e. ADDRESS 1131 Bel Air Rd Bel Air, Md 21014	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-24-87		23c. NAME OF CEMETERY OR CREMATORY St. Josephs Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Hackensack, Bergen, New Jersey		24. FUNERAL DIRECTOR NAME ADDRESS Marzullo Funeral Service Upperco, MD.			
25a. DATE REC'D. BY REGISTRAR OCT 28 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the "Burial-Transit" page, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified.

75 92 123 1 1 5 0 5 0

07051041866

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Margaret J. Glendenning

2a DATE OF DEATH

10/26/87

2b HOUR
10²⁸ P.M.

3 SEX

female

4 RACE

white

5 DATE OF BIRTH

07 02 05

6 AGE (IN YEARS LAST BIRTHDAY)

82

IF UNDER 1 YEAR

IF UNDER 2 HRS

7a BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

Maryland

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

HARFORD

Co. MD

10 CITY OR TOWN OF DEATH

FALLSTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FALLSTON GENERAL HOSP

12a USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Baltimore

13c CITY OR TOWN

Hydes

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

12942 Harford Road 21082

14 FATHER'S NAME

First
Not Known

MIDDLE

LAST

Voekler

15 MOTHER'S MAIDEN NAME

First
Florence

MIDDLE

LAST

Bell

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)
No

(IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO

212-10-4394

17 INFORMANT

Hydes

ADDRESS

Maryland

Margaret F. Crane 12942 Harford Rd. 21082

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Myocardial

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

End stage Ischemic Heart
ABCD, WPD

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

WPD, Resp arrest.

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.)

21f LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 10/16/87 to 10/26/87 that (I) (we) last saw the deceased alive on 10/26/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.

22b SIGNATURE

Ma

M.D.

DEGREE

ATTENDING PHYSICIAN

MEDICAL DIRECTOR ☒

STAFF PHYSICIAN ☐

22c DATE SIGNED

22d PHYSICIAN'S NAME (TYPE OR PRINT)

U.S. NAIR M.D.

22e ADDRESS

2112 Bel air Road. Fallston-MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

Oct 30 1987

23c NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

23d LOCATION

Baltimore

COUNTY

Maryland

24 FUNERAL DIRECTOR

NAME
Leonard J. Ruck, Inc. Baltimore, Maryland

25a DATE REC'D. BY REGISTRAR

OCT 28 1987

25b REGISTRAR'S SIGNATURE

[Signature]

94-28-81

1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b HOUR	
James Michael Gordon-EL								10/ 12/ 19 87								8:00 am	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
MALE	BLACK	JANUARY 31, 1948		39 YRS						10/ 12/ 19 87							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 BALTIMORE CITY OR COUNTY OF DEATH									
MARYLAND		USA		WIDOWED		DIVORCED		Harford County, MD									
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a USUAL OCCUPATION		12b KIND OF BUSINESS OR INDUSTRY											
DARLINGTON		1215 Holoway Rd. (P.D. BDX 213)		DISABLED													
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS									
MD		HARFORD		DARLINGTON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P. O. 213, HOLLOWAY RD, 21034									
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME															
JAMES L. GORDON		HANNAH THOMPSON															
16a WAS DECEASED EVER IN U.S. ARMED FORCES?		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS											
NO		220 5D 1D25		MRS. HANNAH GORDON,		SAME AS #13e											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				Narcotic intoxication													
				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY		21c HOW INJURY OCCURRED		21d INJURY OCCURRED		21e PLACE OF INJURY		21f LOCATION		CITY OR TOWN		COUNTY		STATE	
		10-12 19 87		Subject used drugs		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Home		1215 Holoway Rd.		Dorseytown, Harford, MD					
22a I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Ann M. Dixon, M.D.		Deputy Chief		10/12/87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Ann M. Dixon, M.D.		111 Penn St., Balto., Md. 21201															
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		CITY OR TOWN		COUNTY		STATE					
CREMATION		13OCTOBER87		R. A. FERRIS + COMPANY		WEST CHESTER,						PA.					
24 FUNERAL DIRECTOR		NAME		ADDRESS		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE									
MITCHELL-SMITH FUNERAL HOME, PA HAVRE de GRACE, MD 21078						OCT 20 1987											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

10 15 100 1 3000

Handwritten text, possibly a date or reference number.

BOX: COTTON LINES

Handwritten signature or initials.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

FOR
1 - STATE
REGISTRAR
2 - DECEASED NAME
(TYPE OR PRINT)

1 DECEASED NAME (TYPE OR PRINT) Christina Viola HANSON			2a DATE OF DEATH MONTH DAY YEAR October 26 1987			2b HOUR 10:15 ^{AM}			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12 25 14		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD			
10 CITY OR TOWN OF DEATH Havre de Grace		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland		13b COUNTY Harford		13c CITY OR TOWN Churchville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 105 Glenville Rd. 21028	
14 FATHER'S NAME FIRST MIDDLE LAST Richard Bruggman				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Greenland					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 216-12-5475		17 INFORMANT ADDRESS Hall Hanson (husband) same as above					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPALMOLARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) PNEUMONIA stating the underlying cause last (c) ACUTE RENAL FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 DAYS 1-2 DAYS									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CVA WITH HEMIPARESIS									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Charles R. Eck, Jr						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/26/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Charles R. Eck, Jr						22e ADDRESS 223 W. Bel Air Ave, Aberdeen, Md			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/29/87		23c NAME OF CEMETERY OR CREMATORY Holy Trinity Episcopal Churchville		23d LOCATION CITY OR TOWN COUNTY STATE Harford Md.			
24 FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399						25a DATE REC'D. BY REGISTRAR OCT 30 1987			
						25b REGISTRAR'S SIGNATURE Julia Tarrington			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

170370 NW-54

GRAND JURY
COUNTY OF ...

IN SENATE
JANUARY 1891

REPORT
OF THE

GRAND JURY
FOR THE YEAR

1890-91

IN SENATE

JANUARY 1891

REPORT

OF THE

GRAND JURY

OCT 30 1890

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST Lawrence MIDDLE Joseph LAST HEINLE

2a DATE OF DEATH MONTH DAY YEAR 10 29 87 2b HOUR 5 01 A M

3 SEX

Male

4 RACE

White

5 DATE OF BIRTH

MONTH DAY YEAR March 27, 1915

6 AGE (IN YEARS LAST BIRTHDAY)

72 YRS

7 UNDER 1 YEAR

MONTHS DAYS

8 UNDER 24 HRS

HOURS MIN

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Harford Co MD

10 CITY OR TOWN OF DEATH

Fallston

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Fallston General

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Police Officer

12b KIND OF BUSINESS OR INDUSTRY

Baltimore Co., MD

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Baltimore

13c CITY OR TOWN

Kingsville

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

11197 Sheradale Dr 21087

14 FATHER'S NAME

John Heinle

15 MOTHER'S MAIDEN NAME

Louise Sraver

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

17 INFORMANT

217-05-8621

ADDRESS

Kingsville, MD. Mildred M. Heinle 11197 Sheradale Dr. 21087

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1: DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiovascular Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Ventricular Dysrhythmia

DUE TO, OR AS A CONSEQUENCE OF

(c)

Coronary Artery Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (two rules) (and not) view the body after death

22b SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c DATE SIGNED

10/29/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

George LAWS MD

22e ADDRESS

Fallston General Hospital

23a BURIAL, CREMATION, REMOVAL (IF CREM.)

Burial

23b DATE

Nov 2, 1987

23c NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

23d LOCATION

CITY OR TOWN

Baltimore, MD

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

DIPPEL FUNERAL HOME, INC.

ADDRESS

7110 BELAIR ROAD

BALTIMORE, MARYLAND

21206

25a DATE REC'D BY REGISTRAR

OCT 30 1987

25b REGISTRAR'S SIGNATURE

Julia Swenson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, pages 1 and 2, and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

070410 0101-201

STANDARD
GENERAL INVESTIGATIVE
DIVISION
FEDERAL BUREAU OF
INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]

070029 OCT 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Arthur James Homer			2a DATE OF DEATH MONTH DAY YEAR October 25 1987		2b HOUR 3:38 M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Aug. 18, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD		
10 CITY OR TOWN OF DEATH HARFORD	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor-Mtn.	12b KIND OF BUSINESS OR INDUSTRY Chemical	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland	13b COUNTY Harford	13c CITY OR TOWN Churchville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 8 Woodside Drive 21028	
14 FATHER'S NAME FIRST MIDDLE LAST George W. Homer		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Rosanna Singleton			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-18-2184	17 INFORMANT ADDRESS Juanita D. Homer, 8 Woodside Drive, Churchville Md. 21028			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a SEVERE PULMONARY EMPHYSEMA					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2 OR PART 3)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 10-25-87 to 10-25-87 that (I) (we) last saw the deceased alive on 10-25-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Danten M. Monakil MD		DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/25/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) DANTEN MONAKIL		22e ADDRESS Harford Mem Hospital 21078			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Oct. 29, 1987	23c NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	23d LOCATION CITY OR TOWN COUNTY STATE Harford Md.		
24 FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		25a DATE REC'D BY REGISTRAR OCT 27 1987			
		25b REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

8-23-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the back, it should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the funeral director. Page 3 should be filed with the funeral director. Page 4 should be filed with the funeral director. Page 5 should be filed with the funeral director. Page 6 should be filed with the funeral director. Page 7 should be filed with the funeral director. Page 8 should be filed with the funeral director. Page 9 should be filed with the funeral director. Page 10 should be filed with the funeral director. Page 11 should be filed with the funeral director. Page 12 should be filed with the funeral director. Page 13 should be filed with the funeral director. Page 14 should be filed with the funeral director. Page 15 should be filed with the funeral director. 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October 10, 1937
Dear Mr. [Name]
[Faint text lines]

[Faint text lines]

[Faint text lines]

068541 OCT 14 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) Kenneth Gregory Horn			2a DATE OF DEATH MONTH DAY YEAR Oct. 8 1987		2b HOUR 7:40 P.M.
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Dec. 20, 1912	6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS	7a UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		
10 CITY OR TOWN OF DEATH Harford	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Estimator	12b KIND OF BUSINESS OR INDUSTRY Moving-Storage	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.	13b COUNTY Harford	13c CITY OR TOWN Abingdon	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS 3805 W. Baker St.	
14 FATHER'S NAME FIRST MIDDLE LAST Lewis -- Horn	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth -- McGovern		ADDRESS Md. 21009		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 216-07-7838	17 INFORMANT Mrs. Doris M. Horn, 3805 W. Baker Ave, Abingdon			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIOGENIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MYOCARDIAL FAILURE</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>HYPERTENSION, ARTERIOSCLEROSIS</u>					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22 I certify that (I) (this hospital) attended the deceased from <u>10-5</u> 19 <u>87</u> to <u>10-8</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-8-87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death)					
22a SIGNATURE Dante N. Monakill		DEGREE M.D.		22c DATE SIGNED 10/8/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DANTE N. MONAKILL, MD		22e ADDRESS Anne de Grace, Md 21078			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Oct. 12, 1987	23c NAME OF CEMETERY OR CREMATORY Cokesbury U.M. Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Abingdon Harford Md.		
24 FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		25a DATE REC'D. BY REGISTRAR OCT 13 1987			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

McArthur

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Charlotte B. Hunter</i>			2a DATE OF DEATH MONTH DAY YEAR <i>October 14 1987</i>		2b HOUR <i>4 35 AM</i>
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>Jan. 20, 1903</i>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <i>84</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Hartford</i> MD	
10 CITY OR TOWN OF DEATH <i>Harford</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hartford Mem. Hospital</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY
13a STATE <i>Maryland</i>		13b COUNTY <i>Cecil</i>	13c CITY OR TOWN <i>Perryville</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Charles F. Bauer</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Katherine Pratt</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>218-80-4992</i>		17 INFORMANT ADDRESS <i>Clifford F. Hunter, Jr., Perryville, Md.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <i>CONGESTIVE HEART FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>STROKE</i>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <i>10-5</i> 19 <i>87</i> to <i>10-14</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>10-14</i> 19 <i>87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Dante V. Monakil</i>		DEGREE		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>DANTE V. MONAKIL</i>		22e ADDRESS <i>Harford Md 21078</i>			
23a BURIAL, CREMATION, REMOVAL (RECEIVED) <i>Burial</i>		23b DATE <i>Oct. 16, 1987</i>	23c NAME OF CEMETERY OR CREMATORY <i>Harford Memorial Gardens</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Churchville, Harford, Md.</i>
24 FUNERAL DIRECTOR <i>Eae. A. Patterson & Son</i>		25a DATE REG. BY REGISTRAR <i>OCT 15 1987</i>		25b REGISTRAR'S SIGNATURE <i>Julia Darden-Randall</i>	

BP

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67854 OCT-88

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

29728

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Reba Kyle Ives		2a. DATE OF DEATH MONTH DAY YEAR October 5, 1987		2b. HOUR M 9:05
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 10 18 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.
10. CITY OR TOWN OF DEATH Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maid	12b. KIND OF BUSINESS OR INDUSTRY Domestic
13a. STATE MARYLAND		13b. COUNTY HARFORD	13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST un k.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST w.k.k.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-07-0126		17. INFORMANT ADDRESS Sharon Hiltz 370 Rambleridge Rd. 21123
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Ischemic heart disease c MI DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART II OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22. I certify that (1) this hospital attended the deceased from 9/27 19 87 to 9/30 19 87 that (2) we last saw the deceased alive on 9/30 19 87 , and that (3) my (our) opinion death occurred on the date and hour and from the causes stated above (4) we (I) did not view the body after death.				
22b. SIGNATURE Brian T. Yeo		DEGREE MD		22c. DATE SIGNED 10/5/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRIAN T. YEO M.D.		22e. ADDRESS Union Avenue Havre de Grace, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 10-6-87	23c. NAME OF CEMETERY OR CREMATORY Westview Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville (Baltimore) Md
24. FUNERAL DIRECTOR NAME Raymond C. Finck		ADDRESS Glen Burnie, Md		25a. DATE REC'D. BY REGISTRAR OCT 06 1987
				25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 472 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1824 OCT-807

UNITED STATES OF AMERICA
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION
SALT LAKE CITY, UTAH

REPORT OF THE
SALT LAKE CITY WATER RESOURCES DIVISION
ON THE
SALT LAKE CITY WATER RESOURCES DIVISION

WATER RESOURCES DIVISION
SALT LAKE CITY, UTAH

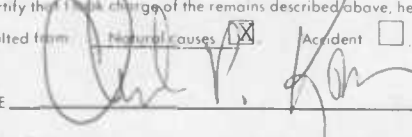
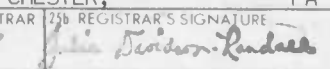
WATER RESOURCES DIVISION
SALT LAKE CITY, UTAH

069162 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

29727

1 DECEASED NAME (TYPE IN PRINT) Martin E. Jackson, SR.			2a DATE KNOWN OF DEATH ESTIMATED 9/ 27/ 19 87			2b HOUR M		
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR OCT 12, 1914	6 AGE IN YEARS (LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YR AGE IN MONTHS DATE HOURS MIN	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD MONTH DAY YEAR 10/ 2/ 19 87	2d HOUR 9:30 P M	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford County MD		
10 CITY OR TOWN OF DEATH Havre de Grace		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 416 Green St.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) TRUCK DRIVER		12b KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED
13 USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION):								
13a STATE MD	13b COUNTY HARFORD	13c CITY OR TOWN HAVRE de GRACE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 416 GREEN STREET		21078		
14 FATHER'S NAME FIRST MIDDLE LAST NORMAN JACKSON			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETTA MARIE LEAGUE					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b SOCIAL SECURITY NO. 217 09 6187		17 INFORMANT ADDRESS 44256 MARTIN E. JACKSON, JR, 4532 WEYMDUTH RD, MEDINA, OH			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that I am in charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER DATE SIGNED 10/4/87		
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.			ADDRESS 111 Penn St, Balto., Md. 21201					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b DATE 8OCTOBER87		23c NAME OF CEMETERY OR CREMATORY R. A. FERRIS + COMPANY		23d LOCATION CITY OR TOWN COUNTY STATE WEST CHESTER, PA	
24 FUNERAL DIRECTOR NAME ADDRESS MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD 21078			25a DATE REC'D BY REGISTRAR OCT 13 1987			25b REGISTRAR'S SIGNATURE 		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL, ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. WORK WITH FORM EM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07-84
25M

BP

DHMH - 17
(VR A15 ME (1))

000105 001500



69325 OCT 22 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arvid NIMN Jacket			2a. DATE OF DEATH MONTH DAY YEAR 10 10 87		2b. HOUR 55 9 AM
3. SEX male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 6 16 1913	6. AGE (IN YEARS (LAST BIRTHDAY)) 74 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD		
10. CITY OR TOWN OF DEATH Harford	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accounting		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Becil	13c. CITY OR TOWN Perryville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 345 Broad St. Apt 16 21903	
14. FATHER'S NAME FIRST MIDDLE LAST N/A		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST N/A			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean War 152-10-8338	17. INFORMANT Dennis Clower 226 FMAN ELKTON MD 21921			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>COPD & respiratory in sufficient way</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hyperglycemia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/26</u> 19 <u>87</u> to <u>10/10</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10/10</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>T. Lee</u>		DEGREE M.D.		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. Lee		22e. ADDRESS Union Med. Clinic			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 10-15-87	23c. NAME OF CEMETERY OR CREMATORY Quantico		23d. LOCATION CITY OR TOWN COUNTY STATE Triand VA	
24. FUNERAL DIRECTOR NAME R. T. Foard		ADDRESS Rising Sun MD		25a. DATE REC'D. BY REGISTRAR OCT 20 1987	
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. The funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dear Mr. [Name] [Address] [City] [State] [Zip]
 I am writing to you regarding the [Topic] [Details] [Information]
 I am writing to you regarding the [Topic] [Details] [Information]
 I am writing to you regarding the [Topic] [Details] [Information]

I am writing to you regarding the [Topic] [Details] [Information]
 I am writing to you regarding the [Topic] [Details] [Information]
 I am writing to you regarding the [Topic] [Details] [Information]
 I am writing to you regarding the [Topic] [Details] [Information]

I am writing to you regarding the [Topic] [Details] [Information]
 I am writing to you regarding the [Topic] [Details] [Information]
 I am writing to you regarding the [Topic] [Details] [Information]
 I am writing to you regarding the [Topic] [Details] [Information]

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29731

1- STATE REGISTRAR												29731																																	
1 DECEASED NAME FIRST MIDDLE LAST Allie O. Johnson												2a DATE KNOWN OF DEATH MONTH DAY YEAR HOUR 10/24 1987 M																																	
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 10/24/35				6 AGE IN YEARS (LAST BIRTHDAY) 52 YRS		IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD MONTH DAY YEAR HOUR 10/24 1987 9a M																															
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD																																	
10 CITY OR TOWN OF DEATH Aberdeen				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 312 Center Dean St.								12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory				12b KIND OF BUSINESS OR INDUSTRY																													
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																																													
13a STATE MD				13b COUNTY Harford				13c CITY OR TOWN Aberdeen				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET ADDRESS 312 Center Dean St. 21001																													
14 FATHER'S NAME FIRST MIDDLE LAST James B.						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie E. Smith																																							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b SOCIAL SECURITY NO. 223-44-0123						17 INFORMANT ADDRESS Robert (husband) same																																	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> } (b) <u>COPD ASCVD</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																																													
19a DATE OF OPERATION												19b CONDITION FOR WHICH OPERATION WAS PERFORMED?												20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																					
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH												21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19												21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK												21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)												21f LOCATION STREET CITY OR TOWN COUNTY STATE																					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																													
ACTUAL SIGNATURE <u>Luis E. Renjel</u>												TITLE (SPECIFY) Deputy MEDICAL EXAMINER												DATE SIGNED 10/24/87																					
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.												ADDRESS 464 Alliance St. Havre De Grace, MD																																	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation												23b DATE 10/29/87												23c NAME OF CEMETERY OR CREMATORY R. A. Ferris & Co.												23d LOCATION CITY OR TOWN COUNTY STATE West Chester Chester Pa.									
24 FUNERAL DIRECTOR NAME Tarrington Funeral Home, PA, Aberdeen, Md. 21001-3399												25a DATE REC'D. BY REGISTRAR OCT 28 1987												25b REGISTRAR'S SIGNATURE																					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

29732

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Betty J Jung</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Oct 26, 1987</i>			2b. HOUR <i>11:53 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>9 25 28</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>59</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD	
10. CITY OR TOWN OF DEATH <i>Harford</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Factory</i>	
12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Bel Air</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <i>2312 Creswell Rd.</i>		13f. CITY OR TOWN <i>21014</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Harry Fisher</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Edna Lowman</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-24-5456</i>		17. INFORMANT ADDRESS <i>Albert Jung, husband, same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Acute Coronary Wall Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Diabetes Mellitus</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Leticia S. Galvez</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10/27/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>LETICIA S. GALVEZ, M.D.</i>		22e. ADDRESS <i>625 S. UNION AVE. HARFORD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10/29/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harford Mem. Gardens</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Aberdeen Harford Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399</i>				25a. DATE RECD. BY REGISTRAR <i>OCT 30 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Baker</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF DEATH ESTIMATED MATED			2b DATE OF DEATH MONTH DAY YEAR			2c DATE OF DEATH MONTH DAY YEAR			2d HOUR		
William			H. T.			Keen			10/16			1987			8p M		
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (LAST BIRTHDAY) YEARS	7 IF UNDER 1 YR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN	9 BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED WIDOWED			9 BALTIMORE CITY OR COUNTY OF DEATH		
M	W	11 14 41	45			Maryland			USA			NEVER MARRIED DIVORCED			Harford MD		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK)			12b KIND OF BUSINESS OR INDUSTRY								
Aberdeen			518 S. Parke St.			Disabled											
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET ADDRESS					
MD			Harford			Aberdeen			YES XX NO			518 S. Parke St.			21001		
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
William H. Keen			Doris Keen														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS								
No			215 40 0199			Doris Keen			518 S. Parke St.			Aberdeen					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) CORONARY HEART DISEASE			
DUE TO, OR AS A CONSEQUENCE OF			
ASCVD			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?	
				YES NO	
21a EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
		Deputy		10/16/87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Luis E. Renjel, M.D.		464 Alliance St. HavreDeGrace, MD			

23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (CITY OR TOWN)		COUNTY		STATE	
Cremation		10/20/87		R. A. Ferris & Co.		West Chester, Chester		Pa.			
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Tarring Funeral Home, PA, Aberdeen, Md.		21001-3399		06/23 1987							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD, "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "FAC-1" (PAGE 5) FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

29734

REG NO

1 DECEASED NAME (TYPE OR PRINT) <i>Lloyd Joseph Keller</i>			2a DATE OF DEATH MONTH DAY YEAR <i>10-5-87</i>		2b HOUR <i>250 PM</i>
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>10 3 11</i>		6 AGE (IN YEARS) (BIRTHDAY) <i>76</i> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD	
10 CITY OR TOWN OF DEATH <i>Fauston</i>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fauston General Hospital</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Truck Driver</i>	12b KIND OF BUSINESS OR INDUSTRY <i>Trucking</i>	
13a STATE <i>Pennsylvania</i>		13b COUNTY <i>Allegheny</i>	13c CITY OR TOWN <i>Bethel Park</i>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <i>2738 Ohio Street 15102</i>
14 FATHER'S NAME FIRST MIDDLE LAST <i>John -- Keller</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Catherine -- Drexler</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no --</i>	
16b SOCIAL SECURITY NO. <i>208-09-2182</i>		17 INFORMANT ADDRESS <i>Valia J. Keller, 2738 Ohio St. Bethel Park, Pa. 15102</i>			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) *Cordiac Arrest*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b) *Cardiogenic Shock*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Massive Myocardial Infarction*

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>10 5 19 87</i>	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8, PART 2, FOR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <i>10/5/87</i> to <i>10/5/87</i> , that (I) (we) last saw the deceased alive on <i>10/5/87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			
22b SIGNATURE <i>Me</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>V-S. NAIR M.D.</i>		22e ADDRESS <i>2112 Rd on Road. Falluta MD</i>	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b DATE <i>Oct. 8, 1987</i>	23c NAME OF CEMETERY OR CREMATORY <i>Queen of Heaven Cemetery, Upper St. Clair-Washington-Pa</i>	23d LOCATION CITY OR TOWN COUNTY STATE
24 FUNERAL HOME <i>Howard K. McComas III, Abingdon, Md. 21009</i>		25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE <i>OCT 07 1987 Julia Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete carbon copies. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10/27/50

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Letter from
to [illegible]
[illegible]

OCT 27 1950

067900 OCT 9 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

29755

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
Dora Theresa Kincaid					Oct.	3	1987		10:35 PM
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	White	May 21 1935		52	MONTHS		DAYS		HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Baltimore, Md.	U.S. A.			Harford Co.		MD			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Hydes	2921 Harford Rd.			Nursing Asst.		St. Joseph Hos.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d INSIDE CITY LIMITS?		13e STREET ADDRESS		
13a STATE		13b COUNTY		13c CITY OR TOWN		YES <input type="checkbox"/> NO <input type="checkbox"/>		2921 Harford Rd. 21082	
Maryland		Harford		Hydes					
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
Vincent		Mary		Frances Ross					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
no		218-34-0027		MR. Delbert Kincaid,		Hydes, Md. 21082			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) <u>respiratory arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>brain tumor</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>12/26</u> 19 <u>85</u> to <u>10/3</u> 19 <u>87</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>5/18</u> 19 <u>87</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> did <u>(did not)</u> view the body after death.									
22b SIGNATURE		DEGREE		22c DATE SIGNED					
<u>David S. Down</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		10/5/87					
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
DAVID S. DOWN		1131 Belair Rd							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial		Oct. 6, 1987		Dulaney Valley Mem. G.		Timonium Balto. Md.			
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
E. F. Lassahn, 11750 Belair Rd.		Kingsville, Md. 21087		OCT 07 1987		<u>Julia Davidson-Rodell</u>			

BP

DHMH 16 25M
1VR A 15 (4) 9/74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

105800 001-301

OCT 07 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in triplicate by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) KINZY, HOWARD		FIRST Howard MIDDLE Samuel LAST Kinzy		2a DATE OF DEATH MONTH DAY YEAR 10 29 87		2b HOUR 12:26 M	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 2 24 1919		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford County MD	
10 CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b KIND OF BUSINESS OR INDUSTRY US-govt. Ret.	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Harford 13c CITY OR TOWN Joppa				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 2907 Trout Terrace 21085	
14 FATHER'S NAME FIRST MIDDLE LAST Grover Cleveland Kinzy				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Cartentier			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 219-05-1865		17 INFORMANT ADDRESS Mrs. Lavora B. Kinzy, 2907 Trout Terrace, Joppa Md. 21085			
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE ~ 4 DAYS DUE TO, OR AS A CONSEQUENCE OF (c) PROSTATE CARCINOMA ~ 2 YRS							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4/20 1986		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE 10/29 87			
22a I certify that (I) (this hospital) attended the deceased from 10/27 87 to 10/29 87 that (I) (we) last saw the deceased alive on 10/27 87 , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Loan P. Edwards DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/29/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Loan P. Edwards				22e ADDRESS 2712 BELAIR RD FALLSTON MD 21047			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Nov. 2, 1987		23c NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		23d LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.	
24 FUNERAL DIRECTOR Howard K. McComas III, Abingdon, Md. 21009				25a DATE REC'D. BY REGISTRAR NOV 2 1987			
				25b REGISTRAR'S SIGNATURE [Signature]			

BP

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

29737

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William H Landers</i>			2a DATE OF DEATH MONTH DAY YEAR <i>Oct. 31 1987</i>			2b HOUR <i>5:35 P</i>	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 13 16</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>71</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i> MD.	
10 CITY OR TOWN OF DEATH <i>HARFORD</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HARFORD Memorial Hospital</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Army</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Aberdeen</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Artie H. Landers</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Iva May Landers</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes WW II</i>			
16b SOCIAL SECURITY NO <i>191-09-1087</i>		17 INFORMANT ADDRESS <i>Rosalind Landers, wife, same as above</i>					

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Interstitial Pneumonitis of</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		<i>11 days</i>	
(b) <i>unknown etiology</i>			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>11 days</i>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>10-22</i> 19 <i>87</i> to <i>10-31</i> 19 <i>87</i> that (I) (we) last saw the deceased alive on <i>10-31</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>[Signature]</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>10-31-87</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>13 PAREKH MD.</i>		22e ADDRESS <i>1908 HARFORD RD FALLSTON MD 21047.</i>					

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>11/4/87</i>		23c NAME OF CEMETERY OR CREMATORY <i>Bel Air Mem. Gardens</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Bel Air Harford Md.</i>	
24 FUNERAL DIRECTOR NAME ADDRESS <i>Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399</i>				25a DATE REC'D BY REGISTRAR <i>NOV 4 1987</i>		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 1/81
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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

29738

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thelma MARIE Leeman			2a DATE OF DEATH MONTH DAY YEAR 10 12 87		2b HOUR 4 ¹ / ₂ M
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 10, 1916		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		
10 CITY OR TOWN OF DEATH Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD			13b COUNTY HARFORD	13c CITY OR TOWN HAVRE de GRACE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 219 10 0825		17 INFORMANT ADDRESS JOSEPH J. LEEMAN, 2811 BARTOL AVE, BALTO., MD 21209	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lung Ca & Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASBP DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 8/15, 19 87 to 10/12, 19 87, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE J. J. Lee		DEGREE M.D.		22c DATE SIGNED 12/1	
22d PHYSICIAN'S NAME (TYPE OR PRINT) J. J. Lee		22e ADDRESS Landon Med. Clinic			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE 12 OCTOBER 87	23c NAME OF CEMETERY OR CREMATORY R. A. FERRIS + COMPANY		23d LOCATION CITY OR TOWN COUNTY STATE WEST CHESTER, PA
24 FUNERAL DIRECTOR NAME MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD 21078			25a DATE REC'D. BY REGISTRAR OCT 13 1987		
			25b REGISTRAR'S SIGNATURE Julia Davidson-Rodell		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other significant event, the medical examiner must be notified at once.

BP

DHMH - 16 50M / 181
(VRA 15, 4)

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OCT 12 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

FRANCES ISABELLE

Long

2a. DATE OF DEATH MONTH DAY YEAR
October 1, 1987

2b. HOUR

9:30 A.M.

3. SEX
FEMALE4. RACE
White5. DATE OF BIRTH
MONTH DAY YEAR
January 14, 19056. AGE (IN YEARS LAST BIRTHDAY)
82 YRSIF UNDER 1 YEAR
MONTHS DAYSIF UNDER 24 HRS
HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland7b. CITIZEN OF WHAT COUNTRY?
U.S.A.8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH
Hampstead County, MD10. CITY OR TOWN OF DEATH
Bel Air11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
129 Briarcliff Lane12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
School Teacher12b. KIND OF BUSINESS OR INDUSTRY
Education

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Hampstead Co.

13c. CITY OR TOWN

Bel Air

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

129 Briarcliff Lane

14. FATHER'S NAME

FIRST MIDDLE LAST
Walton

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
Alice Gorrell16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-18-167417. INFORMANT (Name)
Mr. Arthur C. LongADDRESS
2902 Grier Nursery Road
Forest Hill, Maryland 2105018. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIO PULMONARY ARREST

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MINUTES

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

SEVERE MITRAL STENOSIS

YEARS

DUE TO, OR AS A CONSEQUENCE OF

(c)

Rheumatic heart disease

YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from
to the deceased alive on 9/28/87, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

Oct. 2, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Barry A. Wohl, M.D.

22e. ADDRESS

2003 Rock Spring Road, Forest Hill, Md. 21050

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

Oct. 3, 1987

23c. NAME OF CEMETERY OR CREMATORY

Hampstead Cemetery

23d. LOCATION
CITY OR TOWN

Hampstead, Carroll Co., Maryland 21074

COUNTY

STATE

24. FUNERAL DIRECTOR

Joseph William Foster

50 W. Broadway & Williams St.

ADDRESS

Bel Air, Maryland 21014

25a. DATE REC'D. BY REGISTRAR

Oct 5 1987

25b. REGISTRAR'S SIGNATURE

[Signature]

061148 OCT-1961

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "subject" and "information" are faintly visible.]

[Faint handwritten text at the bottom of the page, including what appears to be a signature and some concluding remarks.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

2 DECEASED NAME
(TYPE OR PRINT)

FIRST GREGOR MIDDLE A. LAST ALEXANDER MacLEOD, SR.
Gregor, A. ALEXANDER MacLEOD

7a DATE OF DEATH MONTH DAY YEAR 7b HOUR
Oct 20 1987 11 30 PM

3 SEX

Male
~~Female~~

4 RACE

White

5 DATE OF BIRTH

MONTH DAY YEAR
Aug. 12, 1910

6 AGE (IN YEARS LAST BIRTHDAY)

77

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 2 YEARS

HOURS MIN

7a BIRTHPLACE

(CITY OR TOWN OR FOREIGN COUNTRY)

Pennsylvania

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Harford

MD

10 CITY OR TOWN OF DEATH

Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Harford Memorial Hospital

12a USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Military

12b KIND OF BUSINESS OR INDUSTRY

USA-Ret.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Md.

13b COUNTY

Harford

13c CITY OR TOWN

Edgewood

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

611 Hornbeam 21040

14 FATHER'S NAME

FIRST Alexander

MIDDLE

LAST

MacLeod

15 MOTHER'S MAIDEN NAME

FIRST Elizabeth

MIDDLE

LAST

Kedar

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

Yes

(IF YES, GIVE WAR OR DATES)

WWII-Korea

16b SOCIAL SECURITY NO

183-01-7687

17 INFORMANT

Elizabeth C. MacLeod, 611 Hornbeam Road, Edgewood, Md. 21040

18 CAUSE OF DEATH Enter only one cause per line for PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) COPD Respiratory arrest
ASCP
(c) DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e PLACE OF INJURY

(AT HOME STREET FACTORY OFFICE FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from Oct. 15, 1987 to Oct. 20, 1987 that (I) (we) last saw the deceased alive on Oct. 20, 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

J. Lee
M.D.
J. Lee

DEGREE

ATTENDING
PHYSICIANMEDICAL
DIRECTOR ☒STAFF
PHYSICIAN ☐

22c DATE SIGNED

10/20/87
J. Lee

22d PHYSICIAN'S NAME (TYPE OR PRINT)

22e ADDRESS

Univ. Med. Clinic
J. Lee

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b DATE

Oct. 23, 1987

23c NAME OF CEMETERY OR CREMATORY

Arlington National Cem.

23d LOCATION

CITY OR TOWN

Arlington - Arlington Va.

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

Howard K. McComas III, Abingdon, Md. 21009

ADDRESS

25a DATE REC'D BY REGISTRAR

OCT 23 1987

25b REGISTRAR'S SIGNATURE

J. Lee
J. Lee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and carefully checked by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

29741

1 DECEASED NAME (TYPE OR PRINT) ROSS Edward Markline			2a DATE OF DEATH MONTH DAY YEAR October 31, 1987		2b HOUR 9:40 M		
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 22, 1913		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10 CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Distributor		12b KIND OF BUSINESS OR INDUSTRY Bottled Gas	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Harford		13c CITY OR TOWN Aberdeen		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John William Slade		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Mary Smith		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 218-32-1874	
17 INFORMANT ADDRESS Aberdeen, Md. 21001		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) COPD, chr. Bronchitis, Emphysema		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ---							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 1987 to 10-31 19 87 , that (I) (we) last saw the deceased alive on 10-31 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE B Parekh				DEGREE M.D.		22c DATE SIGNED 10-31-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) B PAREKH M.D.				22e ADDRESS 1908 HARFORD RD, FALLSTON MD 21047			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Nov. 3, 1987		23c NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air		23d LOCATION CITY OR TOWN COUNTY STATE Harford Md.	
24 FUNERAL DIRECTOR Howard K. McComas III, Abingdon, Md. 21009				25a DATE REC'D. BY REGISTRAR NOV 03 1987		25b REGISTRAR'S SIGNATURE Julia Swanson-Randall	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of one.

Handwritten notes and scribbles at the top of the page, including the word "B-2" and some illegible markings.

Handwritten notes and scribbles in the middle and bottom of the page, including the word "B-2" and some illegible markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anless W. McNutt			2a DATE OF DEATH MONTH DAY YEAR 10 18 87		2b HOUR 11:30 PM
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 10 5 31		6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD	
10 CITY OR TOWN OF DEATH Aberdeen	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 605 Walker St.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Army		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland		13b COUNTY Harford	13c CITY OR TOWN Aberdeen	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 605 Walker St. 21001
14 FATHER'S NAME FIRST MIDDLE LAST Herman Francis McNutt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violola Step			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes	(IF YES, GIVE WAR OR DATES) Korea	16b SOCIAL SECURITY NO. 426-52-8207	17 INFORMANT ADDRESS Anna E. McNutt Same as above		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Calcaneous Pancreas DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART II OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from August 19 87 to October 15 87, that (I) (we) last saw the deceased alive on October 15 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death)					
22b SIGNATURE Myo Thant		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-19-1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MYO THANT		22e ADDRESS 9101 FRANKLIN SO. DR. BALTO, MD 21237			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/21/87	23c NAME OF CEMETERY OR CREMATORY Harford Mem. Gardens		23d LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford Md.	
24 FUNERAL DIRECTOR NAME Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399		25 DATE REC'D BY REGISTRAR OCT 21 1987 REGISTRAR'S SIGNATURE John Burden-Randall			

10 52 130 52 583

BOX COLLECTION 41111

10 52 130

WILKINSON 10 52 130

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068332 OCT 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

29743

1- STATE REGISTRAR		FOR		DATE OF BIRTH		2a DATE KNOWN OF DEATH		2b HOUR	
FEDERAL NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		MONTH DAY YEAR	
Betty		M.		Meredith		10 6 1987		807 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS	7c DATE PRONOUNCED DEAD	8 MONTH DAY YEAR	9 HOUR	10 M
F	W	1 28 33	54 YRS			10 6 1987		807 PM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED	9 NEVER MARRIED	10 DIVORCED	11 BALTIMORE CITY OR COUNTY OF DEATH				
(PA) USA	USA				HARFORD				
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY						
Havre de Grace	HARFORD Memorial	HOMEMAKER							
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS					
MD	1941	Havre de Grace	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1001 Leslie Rd	21078				
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST	FIRST MIDDLE LAST								
CHARLES RUTTER	ELLEN ENGLE								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS						
NO	220-3465N	Lee - Husband	Sonne						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u>									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost									
(b) <u>pulmonary embolism</u>									
(c) <u>DU TO, OR AS A CONSEQUENCE OF</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?							
		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
	P.M. 19								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22b Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
22c TITLE (SPECIFY) M.D. <u>Denise</u> MEDICAL EXAMINER DATE SIGNED <u>10 6 87</u>									
22d EXAMINER'S NAME (TYPE OR PRINT) <u>WIS E RENJEL</u> ADDRESS <u>464 Williams St Havre de Grace 21078</u>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE						
CREMATION	7OCTOBER87	R. A. FERRIS + COMPANY	WEST CHESTER, PA						
24 FUNERAL DIRECTOR NAME	25a DATE REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE							
MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD. 21078	OCT 09 1987	<u>[Signature]</u>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07-84
25M

BP
DHMH - 17
(VR A15 ME (5))

080335 OCT 13 67



080335

067798 OCT 7 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
1b DECEASED NAME (TYPE OR PRINT)		3 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
THEODORE ANDREW MINA, SR		June 23, 1925		62	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Male	White	June 23, 1925		62	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7c CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Maryland	USA			HARFORD MD	
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
FALLSTON	FALLSTON GENERAL HOSPITAL		Sr. Tech. Writer		Electronics
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE	
Maryland	Harford	Joppa		21085 2522 Chilberry Avenue, Joppa Md	
14 FATHER'S NAME (FIRST MIDDLE LAST)		15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)			
Walter Ramond Mina, Sr.		Josephine Elizabeth Kozlowski			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
Yes WWII		218-18-8222		Md. 21085 Elizabeth L. Mina, 2522 Chilberry Ave, Joppa	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Cardiac Arrest					minutes
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction					Months
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Vascular Disease					Years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> ALL WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION (STREET CITY OR TOWN COUNTY STATE)	
22a I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED	
John McNeillat		MD		10/1/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (TYPE IF Y)		23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE	
Burial		Oct. 5, 1987	Holy Rosary's Cemetery	Dundalk Balto Md.	
24 FUNERAL DIRECTOR NAME ADDRESS			25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE
Howard K. McComas III, Abingdon, Md. 21009			OCT 05 1987		Frederick R. Riddle

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and autopsied.

001100 OCT-1961

20% COTTON FIBER

MADE IN U.S.A.



069658 OCT 26 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

29743

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rhoe Wilson Mink			2a DATE OF DEATH MONTH DAY YEAR October 19, 1987		2b HOUR A M 3:00 A
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR March 18, 1912	6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS	IF UNDER 1 YEAR IF UNDER 12 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD		
10 CITY OR TOWN OF DEATH Jarrettsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4058 Federal Hill Road		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance	12b KIND OF BUSINESS OR INDUSTRY Gas	
13a STATE Maryland	13b COUNTY Harford	13c CITY OR TOWN Jarrettsville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 4058 Federal Hill Road 21084	
14 FATHER'S NAME FIRST MIDDLE LAST Granville Sherman Mink		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Belle Hash			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO 218-07-0298	17 INFORMANT Emma M. Mink same as above		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHRONIC LYMPHOCYTIC LEUKEMIA ~ 2 yr DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARREST DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 5 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from above (check) and (2) (the body) did not (check) the body after death.					
22b SIGNATURE <i>[Signature]</i>		DEGREE <i>[Signature]</i>		22c DATE SIGNED 10/19/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. P. Edwards		22e ADDRESS 2112 Bel Air Rd		CITY OR TOWN Harford MD	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/21/87	23c NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gar.	23d LOCATION CITY OR TOWN Bel Air	COUNTY STATE Harford Md.	
24 FUNERAL DIRECTOR NAME ADDRESS M. Gladden Kurtz Jarrettsville, Md.		25 DATE REC'D BY REGISTRAR OCT 21 1987		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant condition, the medical examiner must be notified at once.

06888 OCT 28 07

James Earl Ray
born 5 April 1928
Scottsbluff, Nebraska
USA
Ray, James Earl
born 5 April 1928
Scottsbluff, Nebraska
USA
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born 5 April 1928
Scottsbluff, Nebraska
USA

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born 5 April 1928
Scottsbluff, Nebraska
USA

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) RUSSEL C MORROW			2a DATE OF DEATH MONTH DAY YEAR 10 20 87		2b HOUR 2:29 A.M.
3 SEX M	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR 9 21 34	6 AGE (IN YEARS (LAST BIRTHDAY)) 53 YRS	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	
7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.		
10 CITY OR TOWN OF DEATH MARIE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNK.	
13a STATE MD.		13b COUNTY HARFORD	13c CITY OR TOWN HAVE DE GRACE	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
14 FATHER'S NAME FIRST MIDDLE LAST CECIL CHARLES MORROW		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH E. CULLUM			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK.		16b SOCIAL SECURITY NO. 215-32-5781		17 INFORMANT ADDRESS HELEN WASSUM - sister 159 ALLENDALE RD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>10/18/87</u> to <u>10/20/87</u> , that (I) (we) last saw the deceased alive on <u>10/20/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Dante N. Monakil		DEGREE		22c DATE SIGNED 10/20/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DANTE N. MONAKIL		22e ADDRESS MARIE DE GRACE, MD 21078			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b DATE 10-20-87	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE
24 FUNERAL DIRECTOR (NAME) State Anatomy Board		ADDRESS Balto., Md.		25a DATE REC'D. BY REGISTRAR OCT 21 1987	25b REGISTRAR'S SIGNATURE Julia Gordon-Randall

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

070706 NOV -4 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. DECEASED NAME (TYPE OR PRINT) Martha May Oliver				2a. DATE OF DEATH MONTH DAY YEAR 10 30 87				2b. HOUR 2:25 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 5 1938		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS		7. IF UNDER 1 YEAR MONTH DAY YEAR IF UNDER 15 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Own Home		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Harford		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Golden L. Williams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith McCurry		16. STREET ADDRESS / ZIP CODE 117 Fern Drive 21085			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 379-34-6167		17. INFORMANT William Henry Oliver		ADDRESS Joppa, MD 21085 117 Fern Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident (Stroke) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Severe Lung Infection with Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Restrictive Lung Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs 6 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Malnutrition									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 117 Fern Drive		CITY OR TOWN Joppa		COUNTY Harford	
22a. I certify that (I) (this hospital) attended the deceased from 10-23 19 87 to 10-30 19 87 that (I) (we) last saw the deceased alive on 10-30 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (do not) view the body after death.									
22b. SIGNATURE Willard P. Amos				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-30-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Willard P. Amos				22e. ADDRESS 2303 Belvoir Rd, Fallston, MD 21047					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/3/87		23c. NAME OF CEMETERY OR CREMATORY Higgins Chapel		23d. LOCATION CITY OR TOWN Erwin Unicoi Tenn.			
24. FUNERAL DIRECTOR NAME 7922 Wise Ave. Dundalk, MD 21222 Duda-Ruck Funeral Home of Dundalk, Inc.				25a. DATE REC'D. BY REGISTRAR NOV 03 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

15-3-8-2010
Olive
MVA

15-3-8-2010

15-3-8-2010

15-3-8-2010

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168903 OCT 19 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

29748
7a DATE OF DEATH MONTH DAY YEAR 7b HOUR
Oct. 12 1987 8:01 P1 DECEASED NAME FIRST MIDDLE LAST
(TYPE OR PRINT) Raymond A Pinion3 SEX male 4 RACE Black 5 DATE OF BIRTH MONTH DAY YEAR 3 24 1884 6 AGE (IN YEARS LAST BIRTHDAY) 103 7c UNDER 1 YEAR 7d UNDER 24 HRS
MONTHS DAYS HOURS MIN.7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b CITIZEN OF WHAT COUNTRY? U.S.A. 8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD

10 CITY OR TOWN OF DEATH HARFORD 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARVRE DE GRACE MEMORIAL HOSP 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer 12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Harford 13c CITY OR TOWN Havre deGrace 13d INSIDE CITY LIMITS? YES ☒ NO ☐ 13e STREET ADDRESS 109 George Ct. 21078

14 FATHER'S NAME FIRST MIDDLE LAST Lewis Pinion 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Collins

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) 16b SOCIAL SECURITY NO. 220-22-5569 17 INFORMANT ADDRESS 109-C Hamilton Place Aberdeen, Md. 21001

18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardioresenal failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriolonephrosclerosis > one year

(c) Generalized A.S.C.V.D. 5 years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Hememia

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED 19c AUTOPSY? YES ☐ NO ☒ 19d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2, OR PART 2)

21a INJURY OCCURRED 21b PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC) 21c LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from 10/12/87 to 10/12/87 that (I) (we) last saw the deceased alive on 10/12/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b SIGNATURE Edward C. Loo, M.D. DEGREE M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c DATE SIGNED 10/13/87

22d PHYSICIAN'S NAME (TYPE OR PRINT) Edward C. Loo, M.D. 22e ADDRESS Havre deGrace, Md. 21078

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b DATE 10/15/87 23c NAME OF CEMETERY OR CREMATORY Union United Cemetery 23d LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford Md.

24 FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399 25a DATE REC'D BY REGISTRAR OCT 16 1987 25b REGISTRAR'S SIGNATURE Julia Tarrington-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST <i>Everett</i>		MIDDLE <i>D.</i>		LAST <i>Pyle</i>		2a DATE OF DEATH MONTH DAY YEAR <i>October 27 1987</i>		2b HOUR <i>11 43</i> M	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>August 13 1908</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS		7a IF UNDER 1 YEAR MONTHS DAYS <i>11 2</i>		7b IF UNDER 1 YEAR MONTHS DAYS <i>11 2</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b CITIZEN OF WHAT COUNTRY? <i>United States</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD					
10 CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Mem Hospital</i>						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Bookkeeper</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Packing Company</i>	
13a STATE <i>Maryland</i>				13b COUNTY <i>Harford</i>		13c CITY OR TOWN <i>Whiteford</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <i>2635 Whiteford Road - 21160</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Edward E. Pyle</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertha Duphorn</i>				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>			
16b SOCIAL SECURITY NO. <i>705-10-8951</i>				17 INFORMANT <i>Margaret P. Williams</i>				ADDRESS <i>Havre de Grace, MD 324 South Union Avenue</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardio-genic Shock</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Generalized Vascular Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Abscess lung, hypoxemia</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Gastric-Intestinal Bleed</i>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET <i>10-27</i>		CITY OR TOWN <i>10-27</i>		COUNTY <i>10-27</i>		STATE <i>10-27</i>	
22a I certify that (1) (this hospital) attended the deceased from <i>10-27</i> 19 <i>87</i> to <i>10-27</i> 19 <i>87</i> that (1) (we) lost saw the deceased alive on <i>10-27</i> 19 <i>87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death											
22b SIGNATURE <i>Irvin L. Wachsman</i>						DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>10/28/87</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Irvin L. Wachsman</i>						22e ADDRESS <i>5 Union Ave. Havre de Grace, MD</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>10/31/87</i>		23c NAME OF CEMETERY OR CREMATORY <i>Slate Ridge Cemetery</i>		23d LOCATION CITY OR TOWN <i>Peachbottom Twp., York, PA</i>					
24 FUNERAL DIRECTOR NAME <i>Harkins Funeral Home, Inc. 600 Main St. Delta, PA</i>						25a DATE REC'D BY REGISTRAR <i>OCT 30 1987</i>		25b REGISTRAR'S SIGNATURE <i>Julia S. ...</i>			

010300 1-51

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

OCT 30 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____
DHMH 16 60M 7-84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virgil Ross		2a DATE OF DEATH MONTH DAY YEAR October 24 1987		2b HOUR 50 2 A.M.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 10 6 20	
6a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		6b CITIZEN OF WHAT COUNTRY? U.S.A.		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS MONTHS DAYS HOURS MIN	
7a CITY OR TOWN OF DEATH Harford		7b NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem Hospital		7c BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
8 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Harford		13c CITY OR TOWN Aberdeen	
14 FATHER'S NAME FIRST MIDDLE LAST John Ross		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alta Mae Selvage		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes	
16b SOCIAL SECURITY NO. 030-22-6338		17 INFORMANT Edith Ross S.A.A.		18 CAUSE OF DEATH PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) Gastrointestinal Bleeding DUE TO, OR AS A CONSEQUENCE OF (c) CIRRHOSIS OF LIVER APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 10-19-87 to 10-24-87, that (I) (we) last saw the deceased alive on 10-24-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b SIGNATURE Denton W. Munch		22c DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d DATE SIGNED 10/24/87	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 10/28/87		23c NAME OF CEMETERY OR CREMATORY R. A. Ferris & Co.	
23d LOCATION CITY OR TOWN West Chester, Chester, Pa.		23e DATE REC'D. BY REGISTRAR		23f REGISTRAR'S SIGNATURE	
24 FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399		24b ADDRESS		24c DATE REC'D. BY REGISTRAR OCT 28 1987	

10123 OCT 1907

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of office.

BP _____

DHMH - 16 60M 7-B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

FOR
STATE
REGISTRAR

1- DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

LEONARD

John

SCHENNING.

2a DATE OF DEATH

MONTH

DAY

YEAR

10 19 87

2b HOUR

900 A

3 SEX

MALE

4 RACE

white

5 DATE OF BIRTH

MONTH

DAY

YEAR

12- 27 25

6 AGE (IN YEARS (LAST BIRTHDAY))

61

IF UNDER 1 YEAR

MONTHS

IF UNDER 24 HRS

DAYS

HOURS

MIN.

9 BALTIMORE CITY OR COUNTY OF DEATH

HARFORD

MD

10 CITY OR TOWN OF DEATH

FALLSTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

FALLSTON GENERAL HOSP.

12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Farmer

12b KIND OF BUSINESS OR
INDUSTRY

Dairy

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Harford

13c CITY OR TOWN

Bel Air

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

2816 Calvary Road 21014

14 FATHER'S NAME

Henry

MIDDLE

(mm)

LAST

Schenning

15 MOTHER'S MAIDEN NAME

Barbara

MIDDLE

Anna

LAST

Vasold

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

no

16b SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)

215-36-7938

17 INFORMANT

John E. Schenning, 2816 Calvary Road, Bel Air, Md

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Adenocarcinoma of Lung with Bone-Lymphnode

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

6 months

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT WORK AT WORK

21e PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 10-6 19 87 to 10-19 19 87 that (I) (we) last

saw the deceased alive on 10-18 - 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

B. PAREKH

DEGREE

MD

ATTENDING

PHYSICIAN ☒

MEDICAL

DIRECTOR ☐

STAFF

PHYSICIAN ☐

22c DATE SIGNED

10-19-87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

B. PAREKH MD.

22e ADDRESS

1908 HARFORD RD. FALLSTON MD 21047

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b DATE

Oct. 22, 1987

23c NAME OF CEMETERY OR CREMATORY

Sacred Heart of Jesus Cemetery

23d LOCATION

CITY OR TOWN

Baltimore

COUNTY

Balto

STATE

Md.

24 FUNERAL DIRECTOR

NAME

ADDRESS

Howard K. McComas III, Abingdon, Md. 21009

25a DATE REC'D BY REGISTRAR

OCT 22 1987

25b REGISTRAR'S SIGNATURE

John E. Schenning

000000000000

LEARNER, E. STEVENSON

MALE WHITE 12-27-28

HARRIS

FRUIT

FALL AND WINTER

100000000000

100000000000

100000000000

100000000000

100000000000

100000000000

100000000000

100000000000

100000000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7-84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

2a DATE OF DEATH

MONTH

DAY

YEAR

2b HOUR

(TYPE OR PRINT)

H. HOWARD SCHWANDTNER

10-9-87

1:40 AM

3 SEX

Male

4 RACE

White

5 DATE OF BIRTH

NOV. 6, 1916

6 AGE (IN YEARS LAST BIRTHDAY)

70

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Balto. Co. Md.

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

HARFORD

MD

10 CITY OR TOWN OF DEATH

FALLSTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

FALLSTON GENERAL HOSPITAL

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Carpenter

12b KIND OF BUSINESS OR INDUSTRY

Self-Employed

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Baltimore

13c CITY OR TOWN

Perry Hall

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

4009 Schroeder Ave. 21128

14. FATHER'S NAME

Herman

MIDDLE

LAST

Schwandtner

15 MOTHER'S MAIDEN NAME

Elizabeth

MIDDLE

LAST

Byer

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

no

16b SOCIAL SECURITY NO

216-10-2370

17 INFORMANT

ADDRESS

2532 Greene Rd.

Mrs. Joyce Brewer, Baldwin, Md. 21013

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) CONGESTIVE HEART FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(c) MYOCARDIOSCLEROSIS

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

METASTATIC CARCINOMA OF PROSTATE GLAND

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 9/30, 1987 to 10/9, 1987 that (I) (we) lost

saw the deceased alive on 10/9, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c DATE SIGNED

10/9/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

DANTE MONAKIL

22e ADDRESS

Harrod Grove, Md 21078

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

10-12-1987

23c NAME OF CEMETERY OR CREMATORY

Highview Mem. Gardens

23d LOCATION

CITY OR TOWN

Fallston

COUNTY

Harford

STATE

Md.

24 FUNERAL DIRECTOR

NAME

Kingsville, Md. 21087

F.H. 11750 Belton Rd

25a DATE REC'D BY REGISTRAR

OCT 13 1987

25b REGISTRAR'S SIGNATURE

John Burdick

978 0 130 27488 1

070343 OCT 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copy 1 and 2, and return them to the funeral director. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bessie T. Scott			2a DATE OF DEATH MONTH DAY YEAR 10 21 87		2b HOUR 5 ⁰⁰ A.M.
3 SEX FEMALE	4 RACE BLACK	5 DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE COUNTRY MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD	
10 CITY OR TOWN OF DEATH HARFORD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK	12b KIND OF BUSINESS OR INDUSTRY Private	
13a STATE MARYLAND		13b COUNTY HARFORD	13c CITY OR TOWN HARFORD	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST SAMUEL TURNER		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA LEE		13e STREET ADDRESS / ZIP CODE 4054 BIAVELL HILL RD. 21078	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 220-38-3672	17 INFORMANT ADDRESS Joyce Brown 153 Keystone RD. Chester PA.		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause or stating the underlying cause last (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>old Cardiovascular accident</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>old Cardiovascular accident</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 OR PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____ that (I) (we) last saw the deceased alive on _____, 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22b SIGNATURE [Signature]		DEGREE M.D.		22c DATE SIGNED 10/21/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) SANG W. KIM		22e ADDRESS 308 S. Union Ave. Harford, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 10-26-87	23c NAME OF CEMETERY OR CREMATORY GRAVELL HILL Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE HARFORD HARFORD MD		
24 FUNERAL DIRECTOR NAME Joe and Mrs. Edith [Signature]		ADDRESS 398 [Signature]	25a DATE REC'D. BY REGISTRAR OCT 28 1987	25b REGISTRAR'S SIGNATURE [Signature]	

BP

DHMM - 16 60M 7-B4
(VRA 15, 4)

010010 010010

30% COTTON

WATERFORD



068775 OCT 6 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

Elizabeth

Ann

Sherman

2a DATE KNOWN
OF
DEATH MATED ☒ 10/12/1987

2b HOUR
M

3 SEX

Female

4 RACE

White

5 DATE OF BIRTH

May 18, 1952

6 AGE (IN YEARS)

35 YRS

IF UNDER 1 YR

MONTHS DATE HOURS MIN

IF UNDER 24 HRS

HOURS MIN

2c DATE

PRONOUNCED
DEAD

10/12/1987

2d HOUR

0:15 a M

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Harford County, MD

10 CITY OR TOWN OF DEATH

Bel Air

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

2519 Bradfield Ave.

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Secretary

12b KIND OF BUSINESS OR INDUSTRY

Automotive

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Harford

13c CITY OR TOWN

Bel Air

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS

2519 Bradfield Avenue 21014

14 FATHER'S NAME

William

MIDDLE

Alexander

LAST

Gibson

15 MOTHER'S MAIDEN NAME

Nancy

MIDDLE

Erma

LAST

Edwards

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

no

16b SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

--

17 INFORMANT

213-58-3391

ADDRESS

Bel Air, Md. 21014

William A. Gibson, 2017 Roberson Road,

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Shotgun Wound of Chest & Abdomen

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☒ NO ☐

21a EXTERNAL CAUSE WAS

UNDERLYING ☒ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
XX 10/12/87

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

subject shot

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☒
AT WORK AT WORK

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

home

21f LOCATION

2519 Bradfield Ave., Bel Air, Harford, Md.

22a I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion
death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐.

ACTUAL
SIGNATURE

TITLE (SPECIFY)

M.D. Deputy Chief MEDICAL EXAMINER

DATE
SIGNED 10/12/87EXAMINER'S NAME
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS 111 Penn St., Balto., Md. 21201

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b DATE

Oct. 15, 1987

23c NAME OF CEMETERY OR CREMATORY

Bel Air Memorial Gardens, Bel Air Harford Md.

23d LOCATION
(CITY OR TOWN)

COUNTY

STATE

24 FUNERAL DIRECTOR

Howard K. McComas III, Abingdon, Md. 21009

25a DATE REC'D BY REGISTRAR

OCT 15 1987

25b REGISTRAR'S SIGNATURE

John Davidson-Russell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF A DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE KNOWN OF DEATH ESTI MATED	<input checked="" type="checkbox"/> MONTH DAY YEAR	7b HOUR
		Stevenson Thomas Sherman					<input type="checkbox"/> 10/12/19 87		M
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS) (LAST BIRTHDAY)	IF UNDER 1 YR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	7c DATE PRONOUNCED DEAD	MONTH DAY YEAR	7d HOUR	
Male	White	July 1, 1953	34 YRS			10/ 12/ 87		6:15 a m	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Harford County, MD			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Bel Air		2519 Bradfield Ave.				Mechanic		Auto	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS		13f ADDRESS			
Maryland	Harford	Bel Air	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Md. 21014		2519 Bradfield Avenue, Bel Air			
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Stevenson Donald Sherman			Phyllis Irene Hatcher						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS			
No			213-58-3755			Stevenson Donald Sherman, 2123 Roberson Rd., Bel Air, Md. 21014			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) Shotgun Wound of Chest & Abdomen									
DUE TO, OR AS A CONSEQUENCE OF									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
			xx 10/12/1987		subject shot				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
			home		2519 Bradfield Ave., Bel Air, Harford, Md.				
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED			
Ann M. Dixon, M.D.			M.D. Deputy Chief			10/12/87			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS						
Ann M. Dixon, M.D.			111 Penn St., Balto., Md. 21201						
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial		Oct. 15, 1987		Bel Air Memorial Gardens, Bel Air		Harford Md.			
24 FUNERAL DIRECTOR			25a DATE REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
Howard K. McComas III, Abingdon, Md. 21009			OCT 15 1987			John A. Dixon			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 1, 2, AND 3. A FINAL PAGE FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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OCT 18 1903

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) HUMAN H. SLAYBAUGH			2a. DATE OF DEATH MONTH DAY YEAR Oct 28, 1987		2b. HOUR 5:52 P.M.
3. SEX male	4. RACE CAUCASION	5. DATE OF BIRTH MONTH DAY YEAR 3 23 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOUR MIN.
7a. BIRTHPLACE (COUNTRY) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD	
10. CITY OR TOWN OF DEATH Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY US Govt	
13a. STATE Md.		13b. COUNTY Cecil	13c. CITY OR TOWN Rising Sun	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Box 113, Y2 Louise Cir 21911
14. FATHER'S NAME FIRST MIDDLE LAST Harry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Alice WALTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 207-07-9717		17. INFORMANT MARIAN Slaybaugh Rising Sun MD 21911	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>acute MI</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCDP</u>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME - STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-28-87 to 10-28-87 that (I) (we) last saw the deceased alive on 10-28-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J T Lee M.D.		DEGREE M.D.		22c. DATE SIGNED 10/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J T Lee		ADDRESS Union Med. Clinic			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-1-87	23c. NAME OF CEMETERY OR CREMATORY West Nottingham		23d. LOCATION CITY OR TOWN COUNTY STATE Cecil MD
24. FUNERAL DIRECTOR NAME Richard L. Goodie		ADDRESS Foard Funeral Home Rising Sun, Md		25a. DATE REC'D. BY REGISTRAR NOV 2 1987	25b. REGISTRAR'S SIGNATURE J. T. Lee

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove to the proper papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury or other traumatic event, forward a copy of this certificate to the State Dept. of Health and Mental Hygiene.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Nelson Snouffer				2a. DATE OF DEATH MONTH 10 DAY 19 YEAR 87			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Jan. DAY 22 YEAR 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD	
10. CITY OR TOWN OF DEATH Belair		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belair Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Builder		12b. KIND OF BUSINESS OR INDUSTRY Construction	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Belair		13e. STREET ADDRESS / ZIP CODE 410 MacPhail Rd., 21014	
14. FATHER'S NAME FIRST Oscar MIDDLE Lee LAST Snouffer				15. MOTHER'S MAIDEN NAME FIRST Ada MIDDLE Rebecca LAST Clark			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-09-7522		17. INFORMANT ADDRESS Evelyn L. Miller, 118 Northwood Dr., 21093			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) poor medical status DUE TO, OR AS A CONSEQUENCE OF (c) severe Parkinson							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: intentional failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTED MEDICAL EXAMINER) NO		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (1) this hospital attended the deceased from Oct 8 1985 to 10-19 1987 (we) last saw the deceased alive on Oct 8 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If the body was not seen after death, so state.)							
22a. SIGNATURE Robert A. Duncan				DEGREE MD		22c. DATE SIGNED	
22b. PHYSICIAN'S NAME (IF OTHER)				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 1131 Belair Rd. 21014	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/22/87		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.	
24. FUNERAL DIRECTOR NAME J. E. Lowell Lemmon ADDRESS 10 W. Padonia Rd.				25. DATE RECEIVED BY HEALTH DEPT. (RECEIVED BY HEALTH DEPT.) OCT 22 1987			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATHLEEN N. SOMERS			2a. DATE OF DEATH MONTH DAY YEAR 10 5 87		2b. HOUR 11:45 AM
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 3 22 24		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH XXXXXXXXXXXXXX. HARFORD MD.	
10. CITY OR TOWN OF DEATH PYLESVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4818 CLERMONT MILL RD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASSEMBLY WKER	12b. KIND OF BUSINESS OR INDUSTRY WESTERN ELEC	
13a. STATE MD.			13b. COUNTY HARFORD	13c. CITY OR TOWN PYLESVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST MOLLIE GROOVER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELL GERTRUDE SIMS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 253-20-7039		17. INFORMANT ADDRESS MARTHA GUPTOM- sister - s/a	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/25</u> 19 <u>87</u> to <u>10/8</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>9/25</u> 19 <u>87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>P. Edwards</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. EDWARDS		22e. ADDRESS 3112 BEL AIR RD		22f. CITY OR TOWN BALTIMORE MD 21047	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10-6-87	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME State Anatomy Board			ADDRESS Balto., Md.		25a. DATE RECEIVED BY REGISTRAR OCT 21 1987
			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

070738 NOV -4 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Floyd W. Sparks			2a DATE OF DEATH MONTH DAY YEAR Oct. 31, 1987		2b HOUR 5 ⁴ M
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR Oct. 21, 1937		6 AGE (IN YEARS LAST BIRTHDAY) 50 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD	
10 CITY OR TOWN OF DEATH Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SERVICEMAN		12b KIND OF BUSINESS OR INDUSTRY U.S. ARMY
13a STATE Md.		13b COUNTY Harford	13c CITY OR TOWN Pylesville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST JOHN W. SPARKS		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY B. COCHRAN		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES	
16b SOCIAL SECURITY NO. 218-34-2031		17 INFORMANT ADDRESS PEGGY TCHORYK, CLAYTON, NC. 27520			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cryptococcal meningitis and septicemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Adult Immunodeficiency Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 1)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>10-26</u> 19 <u>87</u> to <u>10-31</u> 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>10-31</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE 		DEGREE		22c DATE SIGNED 31 Oct 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) R.S. Ackhart, MD.		22e ADDRESS 119 W. High Street Elkton, MD 21921			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Nov. 4, 1987		23c NAME OF CEMETERY OR CREMATORY Garrison Forest Vets	
23d LOCATION CITY OR TOWN COUNTY STATE Owings Mills Baltimore MD		23e DATE REC'D. BY REGISTRAR 23f REGISTRAR'S SIGNATURE 11-3-87			
24 FUNERAL DIRECTOR NAME ADDRESS Harkins Funeral Home, Inc., Delta, PA 17314					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove all signatures. Pages 1 and 2 should be filed with the health department within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

BP

DHMH 16 60M 7-84
(VRS 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) <i>Gertrude Anna STRICKER</i>		7a DATE OF DEATH MONTH DAY YEAR <i>Oct 19, 1987 10 19 87</i>		7b HOUR <i>1:20 A.M.</i>	
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>6/12 1916</i>		6 AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <i>71 (71)</i>		7c IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (COUNTRY) <i>Baltimore Maryland</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Fallston (HARFORD CO.) MD</i>		
10 CITY OR TOWN OF DEATH <i>Fallston</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fallston General Hospital</i>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>Maryland</i>		13b COUNTY <i>Harford Co.</i>		13c CITY OR TOWN <i>Forest Hill 21050</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Edward Auer</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MINNIE Schelhaus</i>		13e STREET ADDRESS / ZIP CODE <i>2907 Smithson Drive 21050</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <i>214-01-7218</i>		17 INFORMANT (NAME) <i>(Daughter) Mrs. Claire A. Hull</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>intracranial hypertension</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>diffuse intracerebral metastases</i>		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Recent Colon Polyps</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10/19/87</i>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>sinusitis, pneumonia</i>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>10/16/87</i> 19 to <i>10/19/87</i> 19 that (I) (we) lost saw the deceased alive on <i>10/19/87</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Patricia A. Weber</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <i>10/19/87</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>WEBER M.D.</i>		22e ADDRESS <i>Fallston General Hospital</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Entombment</i>		23b DATE <i>Oct. 21, 1987</i>		23c NAME OF CEMETERY OR CREMATORY <i>mausoleum Deltona Memorial Gardens</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Deltona, Florida</i>	
24 FUNERAL DIRECTOR <i>Joseph William Foster</i>		50 W. Broadway & Williams St Bel Air, Maryland 21014		25a DATE REC'D. BY REGISTRAR <i>OCT 20 1987</i>		25b REGISTRAR'S SIGNATURE <i>Jana Davidson</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

068333 OCT 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Henry J. Sturm</i>			2a DATE OF DEATH MONTH DAY YEAR <i>October 7, 1987</i>		2b HOUR MIN <i>11:32 A</i>
3 SEX <i>Male</i>	4 RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Jan 22 1901</i>		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN <i>86</i>	7 UNDER 1 YEAR IF UNDER 24 HRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>W. Virginia</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD	
10 CITY OR TOWN OF DEATH <i>Harford</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hospital</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Agriculture</i>
13a STATE <i>Maryland</i>		13b COUNTY <i>Harford</i>	13c CITY OR TOWN <i>Darlington</i>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS <i>3625 Dublin Rd.</i>
14 FATHER'S NAME FIRST MIDDLE LAST <i>Samuel C. Sturm</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Dora Harris</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>	
16b SOCIAL SECURITY NO <i>235-50-7876</i>		17 INFORMANT ADDRESS <i>Henry J. Sturm, 3625 Dublin Rd., Darlington MD, 21034</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Ascar</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Stroke</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>J. T. Lee</i>		DEGREE <i>M.D.</i>		22c DATE SIGNED <i>10/7/87</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. T. Lee</i>		22e ADDRESS <i>Union Med Clinic Harford</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>Oct. 11, 1987</i>	23c NAME OF CEMETERY OR CREMATORY <i>Trinity Cemetery</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Bellington Barbour W.Va.</i>
24 FUNERAL DIRECTOR NAME <i>Harkins Funeral Home, Inc., 600 Main St., Delta, Pa.</i>				25a DATE REC'D BY REGISTRAR <i>OCT 09 1987</i>	25b REGISTRAR'S SIGNATURE <i>[Signature]</i>

BP _____

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1- STATE REGISTRAR		REG. NO.		2a DATE OF DEATH		MONTH		DAY		YEAR		2b HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		October 2		1987		5 45 AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 1 YEAR		IF UNDER 1 YEAR	
m		C white		Oct. 15, 1914		72		YRS		MONTHS		DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Italy		U.S.A.				Harford County				3818 Marcus Court, Monkton		retired	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE		12b KIND OF BUSINESS OR INDUSTRY		Beth. Steel	
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1547 E. 36th Street,				21218	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			
Frank		Julia		No		213-07-8147		Mrs. Terzigni,		21218			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY	
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
DUE TO, OR AS A CONSEQUENCE OF (b) PROSTATIC CARCINOMA												21d INJURY OCCURRED	
DUE TO, OR AS A CONSEQUENCE OF (c)												21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												21f LOCATION (CITY OR TOWN, COUNTY, STATE)	
												22a I certify that (1) this hospital attended the deceased from 8/23/87 to 10/2/87 and that (2) my opinion of death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death)	
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		22f MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22g DATE SIGNED		22h REGISTRAR'S SIGNATURE	
John F. Edwards		10/2/87		John F. Edwards		112 S. 2nd St. Annapolis, Md. 21407						Julia Terzigni-Randall	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (CITY OR TOWN, COUNTY, STATE)		23e DATE REC'D. BY REGISTRAR		23f REGISTRAR'S SIGNATURE			
Entombment		10/6/87		Dulaney Valley Maus. Timonium, Md.				OCT 7 1987					
24 FUNERAL DIRECTOR (NAME)		24b ADDRESS		24c DATE REC'D. BY REGISTRAR		24d REGISTRAR'S SIGNATURE							
Joseph N. Zannino, 263 S. Conkling St.													

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Joseph W. Manning, 503 S. Conkling St.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

29763

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FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET MAE TESTERMAN			2a. DATE OF DEATH MONTH DAY YEAR October 6, 1987		2b. HOUR MIN 6:20 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan. 14, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 81
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford County
10 CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2313 Calvary Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Joseph -- Leftridge		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah -- Tibbs		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no --		
16b. SOCIAL SECURITY NO. 215-28-1093		17 INFORMANT ADDRESS Carol L. Forbes, 3917 Grier Nursery Road, Street, Md. 21154				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) old age DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) Ascaris DUE TO, OR AS A CONSEQUENCE OF (c) Ascaris						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN REMARKS, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE John D. Yun				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-7-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN D. YUN				22e. ADDRESS 319 Union Avenue, Havre de Grace, Md. 21078		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 9, 1987		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air		23d. LOCATION CITY OR TOWN COUNTY STATE Harford Md.
24 FUNERAL DIRECTOR Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D BY REGISTRAR OCT 8 1987		
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

COTTON-PIRE

W. J. ...
...

070678 NOV -1-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

29764

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ada Thompson		2a. DATE OF DEATH MONTH DAY YEAR October 31 1987		2b. HOUR 10:30 A.M.	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Dec 13, 1907	
6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		9b. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
11. CITY OR TOWN OF DEATH Havre de Grace		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	
14. STATE Maryland		15. COUNTY Harford		16. CITY OR TOWN Churchville	
17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS 204 Asbuey Rd. 21028		19. KIND OF BUSINESS OR INDUSTRY Drug Store	
20. FATHER'S NAME FIRST MIDDLE LAST CARROLL Thompson		21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE Johnson		22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
23. SOCIAL SECURITY NO. 218-18-7539		24. INFORMANT Mildred Davis		25. ADDRESS Churchville, Md	

26. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>of stress w/ abuse</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>metastases of cancer</u> DUE TO, OR AS A CONSEQUENCE OF <u>& sepsis</u> (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Anemia - Obstruction with age</u>			
27a. DATE OF OPERATION		27b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
27c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		27d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
27e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		27f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2 OR PART 2)	
27g. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		27h. LOCATION STREET CITY OR TOWN COUNTY STATE	

27i. I certify that (I) (this hospital) attended the deceased from 10/19 1987 to 10/31 1987, that (I) (we) last saw the deceased alive on 10/31 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

27j. SIGNATURE <u>CECIL T. CARROLL</u>		DEGREE		27k. DATE SIGNED <u>10/31/87</u>	
27l. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CECIL T. CARROLL</u>		27m. ADDRESS <u>2012 Edgewood Rd</u> <u>Edgewood 21040</u>		27n. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

28a. BURIAL CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		28b. DATE <u>Nov. 5, 87</u>		28c. NAME OF CEMETERY OR CREMATORY <u>Asbuey Meth Cem</u>	
28d. LOCATION CITY OR TOWN COUNTY STATE <u>Churchville, Harford, Md.</u>		28e. DATE REC'D BY REGISTRAR <u>NOV 3 1987</u>		28f. REGISTRAR'S SIGNATURE <u>in Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

704-301 050070

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 8-10 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				2. DATE OF DEATH				3. HOUR	
1. DECEASED NAME (PRINT)				2a. DATE OF DEATH				2b. HOUR	
ELIZABETH Brinker Van Gosen				10 - 23 - 87				3:43 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Caucasian		Oct. 27, 1916		70 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				HARFORD COUNTY MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
FALLSTON, MD		FALLSTON GEN. HOSPITAL				Teacher Aid		Education	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland				Harford		Forest Hill		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16. SOCIAL SECURITY NO.	
Augustus Clements Brinker				Elisabeth Foard				217-09-2814	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				17b. INFORMANT				ADDRESS	
No				Max R. VanGosen				same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOPUL. DYSF.</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF COLON WITH METS.</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>METS.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
10/21/87		CA. COLON - colectomy				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION			
		HOUR A.M. MONTH DAY YEAR		INJURY OCCURRED		CITY OR TOWN COUNTY STATE			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. LOCATION			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>		AT HOME <input type="checkbox"/> STREET <input type="checkbox"/> FACTORY <input type="checkbox"/> OFFICE <input type="checkbox"/> FARM <input type="checkbox"/> ETC.		STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) the hospital attended the deceased from 10/11/87 to 10/23/87 that (II) the deceased died on 10/23/87 and that in my opinion death occurred on the date and hour and from the causes stated above; (II) we (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
H. McWilliams				MD				10/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				22f. ADDRESS	
H. McWilliams				F.G.H.				F.G.H.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		10/26/87		Centre Cemetery		Forest Hill, Harford, Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
M. Gladden Kurtz Jarrettsville, Md.				OCT 28 1987				M. Davidson	

7034 001337

Twelve January 1913

U.S.A.

My dear Mr. ...
I have the honor to acknowledge the receipt of your letter of the 10th inst.

Respectfully,
Yours very truly,

Wm. H. ...

Very truly yours,
Wm. H. ...

Wm. H. ...

Wm. H. ...

Wm. H. ...

Wm. H. ...

069503 OCT 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
Louis				Vidmar	October 16, 1987				2 A. M.
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	White		October 2, 1923		64		MONTHS		DAYS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
CAPITOL PARK PENNSYLVANIA		U.S.A.				Harford County,		MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Bel Air		1334 Saratoga Drive			Electrical Engineer		Machinery Mfg.		
13a STATE		13b COUNTY	13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS		
Maryland		Harford Co.	Bel Air		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1334 Saratoga Drive 21014		
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
Anton		Mary		Frontes					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT (Wife) 879-2089 ADDRESS 1334 Saratoga Drive					
NO		204-16-6929		Mrs. Florence Vidmar Bel Air, Maryland 21014					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>General debilitation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic colon carcinoma</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
MEDICAL CERTIFICATION									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (a) (we) (did) (did not) view the body after death.		22b SIGNATURE <u>Robert L. Smith</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/16/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
Robert L. Smith		Fallston General Hospital							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial		Oct. 19, 1987		Highview Memorial Gardens		Fallston, Harford Co., Maryland 21047			
24 FUNERAL DIRECTOR		25a DATE REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE				
Joseph William Foster Foster Williams Inc		30 W. Broadway & Williams St. Bel Air, Maryland 21014			Oct 20 1987				

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

1962 10 20 230

1. The following information was obtained from the records of the Department of the Interior, Bureau of Land Management, regarding the land owned by the United States in the State of California.

2. The land is located in the County of San Diego, State of California, and is known as the [illegible] Tract.

3. The land is situated in the [illegible] Section, Township [illegible], Range [illegible], and is bounded by [illegible] on the north, [illegible] on the south, [illegible] on the east, and [illegible] on the west.

4. The land is owned by the United States of America, and is held in trust for the benefit of the people of the State of California.

5. The land is subject to the provisions of the [illegible] Act, and is to be used for [illegible] purposes.

6. The land is to be managed in accordance with the provisions of the [illegible] Act, and is to be used for [illegible] purposes.

7. The land is to be managed in accordance with the provisions of the [illegible] Act, and is to be used for [illegible] purposes.

8. The land is to be managed in accordance with the provisions of the [illegible] Act, and is to be used for [illegible] purposes.

9. The land is to be managed in accordance with the provisions of the [illegible] Act, and is to be used for [illegible] purposes.

10. The land is to be managed in accordance with the provisions of the [illegible] Act, and is to be used for [illegible] purposes.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (BY OR PRINT)		2a. DATE OF DEATH		7b. HOUR	
Fields MACK Ward		10/26/87		8:30 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS, LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	01 23 11	76 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	US		HARFORD MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Fallston	Fallston General Hospital		Painter	Painting	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Harford	Bel Air	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	431 East Broadway 21014	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Crockett		Perlina		Weatherman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS		
No		227-03-2301	Mrs. Naomi T. Ward, 431 E. Broadway, Bel Air, Md. 21014		
18. CAUSE OF DEATH (Enter only one cause per line. Do not include PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>General Debilitation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rube Pneumonia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (a) (this hospital) attended the deceased from 10/25/87 to 10/27/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Robert L. Smith				10/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		Oct. 29, 1987	Bel Air Memorial Gardens		Bel Air Harford Md.
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard K. McComas III, Abingdon, Md. 21009		OCT 28 1987			

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100000

10/20/61

MAKING

Cardinal's
Council
of the

10/20/61

Robert L. Smith

068781 OCT 15 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

DECEASED NAME FIRST MIDDLE LAST <i>Dorothy Reece Williams</i>			2a DATE OF DEATH MONTH DAY YEAR <i>10 13 87</i>		2b HOUR <i>10:14 A.M.</i>
3 SEX <i>Female</i>	4 RACE <i>Cauc.</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>09 13 27</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>60</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (COUNTRY) <i>North Carolina</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD	
10 CITY OR TOWN OF DEATH <i>Fallston</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fallston General Hospital</i>		12a USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE) <i>Homemaker</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>
13a STATE <i>MD</i>			13b COUNTY <i>Harford</i>	13c CITY OR TOWN <i>Edgewood</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <i>Allen Eastridges</i>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertha Wilcox</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>245-30-7316</i>		17 INFORMANT <i>Robert A. Williams, 1866 Eloise Lane 21040</i>	
18 CAUSE OF DEATH Enter only one cause per line for a, b, and c. PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory Arrest/Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last b) <i>COPD</i> DUE TO, OR AS A CONSEQUENCE OF c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>7/15 56</i> to <i>10/13 87</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from <i>7/15 56</i> to <i>10/13 87</i> that (2) I (we) last saw the deceased alive on <i>10/19 87</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)					
22b SIGNATURE <i>David J. Grace</i>		DEGREE		22c DATE SIGNED <i>10-13-87</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>David J. Grace MD</i>		22e ADDRESS <i>212 So Bond Bel Air, MD</i>			
23a BURIAL, CREMATION, REMOVAL (TYPE IF Y)	23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
<i>Cremation</i>	<i>Oct. 14, 1987</i>	<i>Green Mount</i>		<i>Baltimore Md.</i>	
24 FUNERAL DIRECTOR <i>ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, Md. 21214</i>			25a DATE REC'D. BY REGISTRAR <i>OCT 15 1987</i>		
			25b REGISTRAR'S SIGNATURE <i>Julia Davidson</i>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

060701 OCT 1961

RECEIVED
MAY 1962

OCT 15 1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

070627

NOV 3 1987

1- FOR
STATE
REGISTRAR

1- DECEASED NAME FIRST MIDDLE LAST THERESA PALMER WILLIAMS				2a DATE OF DEATH MONTH DAY YEAR 10 28 87		2b HOUR 8 P M	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR MARCH 4, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS	
7a BIRTHPLACE (STATE & FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD	
10 CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
13a STATE MD		13b COUNTY HARFORD		13c CITY OR TOWN HAVRE de GRACE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST CHARLES EDWIN PALMER		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BEADIE ESTELLE SINCLAIR		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 213 14 9010	
17 INFORMANT ADDRESS FREDERICK A. WILLIAMS, JR., 1107 REVOLUTION ST., HdG, MD							

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) old age

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

MEDICAL CERTIFICATION

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN REMARKS PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY TOWN COUNTY STATE			
22a I certify that (1) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (1) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (that) (I) (we) last saw the body after death.							
22b SIGNATURE <i>John D. Yun</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/29/87	
22d PHYSICIAN'S NAME (THROUGH PRINT) John D. Yun				22e ADDRESS Havre de Grace, Md			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 31 OCTOBER 87		23c NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY		23d LOCATION (CITY OR TOWN) COUNTY STATE HAVRE de GRACE, HARFORD CO., MD.	
24 FUNERAL DIRECTOR NAME ADDRESS MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD. 21078				25a DATE REC'D. BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodgers</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is marked, injury or other traumatic event, the medical examiner must be notified at once.

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TO 20 01 847

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RECEIVED ON 10/10/84



RECEIVED 10/10/84

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